Management of Non-Variceal Upper GI Haemorrhage Clinical Guideline

V2.0

August 2019
Summary

Suspected Non Variceal upper GI haemorrhage
If any features suggest liver disease consult the variceal haemorrhage guideline

Assessment & Resuscitation
• Assess patient and fluid resuscitate as necessary
• Adequate IV access, FBC, U&E, LFTs, INR
• Risk assessment using Glasgow Blatchford Score

GBS 2 or less
• Refer to Low Risk GI Bleed guideline

GBS>2; cardiovascularly stable
• Review anti-platelets and anticoagulants (see guidance)
• Upper GI endoscopy within 24 hrs

GBS>2; systolic BP<100 or p>100
• Resuscitate with fluid to Hb 70g/l
• Review anti-platelets and anticoagulants (see guidance)
• Discuss with on-call gastroenterologist
• Endoscopy within 2 hrs of stabilisation
• Care to be taken over by gastroenterology

Post Endoscopy
• Risk assessment (Rockall score)
• Treatment plan directed by the endoscopist
• Re-bleeds should be discussed with the on-call gastroenterologist

GBS = Glasgow Blatchford Score
1. **Aim/Purpose of this Guideline**

1.1. To provide guidelines for medical staff when caring for patients with non-variceal upper GI haemorrhage that fall without the low risk gastrointestinal haemorrhage guideline.

1.2. Responsibility: Medical staff caring for patients with suspected non variceal upper GI bleeding in Royal Cornwall Hospital Trust.

1.3. This version supersedes any previous versions of this document.

1.4. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net

2. **The Guidance**

2.1. **Initial Management and General Points**

- Consider acute upper GI haemorrhage in patients presenting with:
  - Haematemesis
  - Melaena
  - Cardiovascular instability with hypovolaemia with no overt blood loss

- Assess patient and secure venous access. Resuscitate as clinically indicated and check:
  - FBC, INR
  - U&E, LFT
  - G&S

- Assess severity using the Glasgow Blatchford Score.
• Use the variceal bleeding guidelines if features of chronic liver disease (from examination or investigations).
  [Link](http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Gastroenterology/BleedingVarices.pdf)

### 2.2. Patients on anticoagulant/antiplatelet therapy.

- Withhold anticoagulants/antiplatelets for low risk comorbidity (e.g. solitary AF, single episode DVT/PE >3 months ago, PCI >12 months ago etc.) Decision regarding restarting such therapy should be made after the endoscopy.
- Multidisciplinary approach is needed for high risk comorbidity, (e.g. recent MI or CVE within 6 weeks, PCI in last 12 months, recent coronary or peripheral artery bypass grafting, multiple, large and recent PE, procoagulant patients, patients with metallic valve replacement etc.) Discuss with gastroenterologist in the first instance and cardiologist/stroke physician and haematologist as deemed appropriate before giving the next dose.
- Aspirin for secondary prophylaxis should be recommenced as soon as haemostasis achieved
2.3. Low risk GI Bleed; GBC 2 or less
- Consider for discharge and next day endoscopy
- Refer to guideline http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Gastroenterology/ManagementOfUpperGIHaemorrhage.pdf

2.4. GBS >2 cardiovascularly stable
- Refer for endoscopy to be performed within 24 hours
- No benefit in commencing PPI in PPI naïve patients

2.5. GBS >2 with cardiovascular instability
- Fluid resuscitate
- Aim for Hb 70g/l (90 g/l if ischaemic heart disease)
- Liaise with on-call gastroenterologist and endoscope within 2 hr of stabilisation or as advised by consultant gastroenterologist
- Patient transferred to gastroenterology care

2.6. Patient with hypovolaemic shock and massive GI bleeding
- Secure venous access with 2 large bore cannulae
- Resuscitate with fluids
- Catheterise for strict hourly intake/output monitoring
- Discuss with on call gastroenterologist and HDU/ITU staff for consideration of admission.
- Chest x-ray if suspicion of aspiration
- General recommendations are outlined as below:
  o Target Hb is 70-80 (over-transfusion may be as damaging as under-transfusion)
  o Platelet transfusion should be given if actively bleeding and platelet count less than 50 x 10^9/litre. This is not needed if patient is not actively bleeding and is haemodynamically stable
  o FFP (fresh frozen plasma) should be administered if actively bleeding and PT (prothrombin time), INR (international normalized ratio), or APTT (activated partial thromboplastin time) is greater than 1.5 times normal
  o Cryoprecipitate should be given if fibrinogen level remains less than 1.5 g/litre despite fresh frozen plasma transfusion
  o Prothrombin complex concentrate should be given if patient is on warfarin and actively bleeding
  o Recombinant factor Vlla should not be used except when all other methods have failed
  o If the patient is on NOACs (Dabigatrin, Apixaban, Rivaroxaban), refer to guidelines and liaise with on call haematologist for advice regarding reversal as required
- For massive blood loss, blood products should be administered according to massive haemorrhage transfusion protocol which can be found in the blood transfusion policy: http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Haematology/BloodTransfusionPolicy.pdf
2.7. Endoscopy Arrangement:
- OGD should be requested online by Maxims> internal referrals> Endoscopy> Upper GI therapeutic.
- Endoscopy unit can be contacted on x3247
- For large GI bleeds during working hours (Mon-Fri 8.30 – 17.30) all referrals should be directly to the ward gastroenterologist (identified via switchboard). Out of these hours, on call consultant can be contacted via switchboard

2.8. Endoscopic Treatment:
- This guidance is targeted to the endoscopist providing therapeutic endoscopy service for non-variceal upper GI bleeding.
- Adrenaline should not be used as monotherapy
- Use of one of the following methods is recommended:
  - A mechanical method (for example, clips) with or without adrenaline
  - Thermal coagulation with adrenaline
  - Haemospray
- Calculate Rockall score after endoscopy
- OGD report should provide post endoscopy management plan and a plan in case of rebleeding.
- A repeat endoscopy should be arranged for all patients at high risk of rebleeding if there is doubt about adequate haemostasis at the first endoscopy at 24 hr
- Repeat further therapeutic endoscopy should be offered to patients who rebleed and if it is considered endotherapy may be beneficial.
- Interventional radiology treatment or emergency surgery may be appropriate if re-bleeding occurs after 2nd failed therapeutic endoscopy

2.9. Management after Endoscopy
- Calculate full Rockall score
- Follow recommendations made on endoscopy report
- Following therapeutic intervention PPI should be given as an 80mg bolus then 8mg/hr for 72 hours
- Helicobacter pylori eradication should be given if infection detected
- If H. Pylori eradication therapy is provided, request the GP to arrange for Urea breath test 6 weeks after.
- Gastric Ulcers: ensure prescription of Omeprazole 40mg od for 6 weeks. All gastric ulcers need repeat OGD and biopsy 6-8 weeks unless specified otherwise; ensure this is requested prior to discharge.
- **Duodenal ulcers/Duodenitis/Gastritis**: ensure prescription of Omeprazole 40mg od for 6 weeks
- Patients who are taking ulcerogenic drugs/anticoagulants/antiplatelets or have significant/multiple co-morbidity associated with high risk of GI bleeding should be on long term PPI.
2.10. Prevention of re-bleeding in patients on antiplatelet therapy and anticoagulant therapy:
- Low-dose aspirin can be continued for secondary prevention of vascular events in whom haemostasis has been achieved (high bleeding but overall low mortality)
- Other non-steroidal anti-inflammatory drugs (including cyclooxygenase-2 [COX-2] inhibitors) should be stopped during the acute phase
- Complex cases
  - In cases where dual antiplatelet therapy and/or anticoagulants are required and complicated by GI haemorrhage; these patients require multidisciplinary decision making on an individual bases. The discussion should involve the patient, gastroenterologist, cardiologist and haematologist as appropriate.

2.11. Abbreviations used in this document:
- AF: Atrial Fibrillation
- CVA: Cerebrovascular event
- MI: Myocardial Infarction
- PPI: Proton Pump Inhibitor
- PCI: Percutaneous Coronary Intervention
- PE: Pulmonary Embolism
- GBS: Glasgow Blatchford Score
- OGD: Oesophago-gastro-duodenoscopy

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Audit of management of non-variceal bleeding</th>
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<tr>
<td>Lead</td>
<td>Dr Nick Michell</td>
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<tr>
<td>Tool</td>
<td>Scorpio endoscopy reporting system, Maxims, patient notes</td>
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<td>Frequency</td>
<td>Annual</td>
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<td>Reporting arrangements</td>
<td>Gastroenterology governance meetings</td>
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<td>Acting on recommendations and Lead(s)</td>
<td>A team member to be identified who will lead for acting on recommendation.</td>
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<td>Change in practice and lessons to be shared</td>
<td>Minutes from the governance meeting to be shared with teams. A member of team will be identified to lead this. Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
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4. **Equality and Diversity**

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Management of Non-Variceal Upper GI Haemorrhage Clinical Guideline V2.0</th>
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<tr>
<td>Date Issued/Approved:</td>
<td>18/07/2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>August 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>August 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr J Worthington, Gastroenterology</td>
</tr>
<tr>
<td>Contact details:</td>
<td>Department of Gastroenterology, Royal Cornwall Hospitals NHS Trust</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>A step by step guideline for medical staff who are managing a patient with non-variceal upper GI haemorrhage</td>
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<td>Suggested Keywords:</td>
<td>Upper GI bleeding, haemorrhage, OGD, gastrointestinal, endoscopy, gastroenterology</td>
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<td>Target Audience</td>
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<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>18/07/2019</td>
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<tr>
<td>This document replaces (exact title of previous version):</td>
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<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Speciality Care Group, Specialist Services and Surgery Care Group</td>
</tr>
<tr>
<td>Care Group General Manager confirming approval processes</td>
<td>Roz Davies</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
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<tr>
<td>Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings</td>
<td>{Original Copy Signed}</td>
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<tr>
<td>Name: Maria Lane</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
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<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
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## Appendix 2. Initial Equality Impact Assessment Form

<table>
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<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Management of non-variceal upper GI haemorrhage Clinical Guideline V2.0</th>
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<td>Gastroenterology</td>
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<td>New or existing document:</td>
<td>Existing</td>
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<tr>
<td>Name of individual completing assessment:</td>
<td>Joy Worthington</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872 252717</td>
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1. **Policy Aim***

   *Who is the strategy / policy / proposal / service function aimed at?*

   Clinical Guidelines for management of non-variceal of upper GI haemorrhage

2. **Policy Objectives***

   *Who is the strategy / policy / proposal / service function aimed at?*

   To provide guidance to the medical staff at Royal Cornwall Hospitals NHS Trust who are managing patients with non-variceal upper GI Haemorrhage

3. **Policy – intended Outcomes***

   *Who is the strategy / policy / proposal / service function aimed at?*

   Patient safety, standardisation of care, time, and cost effectiveness, accountability

4. **How will you measure the outcome?***

   *Who is the strategy / policy / proposal / service function aimed at?*

   Clinical audit

5. **Who is intended to benefit from the policy?***

   *Who is the strategy / policy / proposal / service function aimed at?*

   Patients, medical staff, Royal Cornwall Hospitals NHS Trust

6a. **Who did you consult with***

   *Who is the strategy / policy / proposal / service function aimed at?*

   Workforce  Patients  Local groups  External organisations  Other

   ✓  

   Clinical Staff

6b. **Please identify the groups who have been consulted about this procedure.***

   *Who is the strategy / policy / proposal / service function aimed at?*

   Clinical Staff

   Agreed

7. **The Impact***

   Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

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Management of Non-Variceal Upper GI Haemorrhage Clinical Guideline V2.0
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Are there concerns that the policy could have differential impact on:

<table>
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<th>Equality Strands</th>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or 
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No ✓

9. If you are not recommending a Full Impact assessment please explain why.

Not indicated
This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust’s web site.