UPPER GI BLEED

Variceal & non-variceal · resuscitate, scope, treat

RESUSCITATE
then scope

RESUSCITATE FIRST: 2 large-bore IV, bloods + group & crossmatch, restrictive transfusion (Hb target 70-80 g/L), correct coagulopathy / platelets, risk-score. Endoscopy after stabilising, ideally < 12 h.

VARICEAL

known / suspected cirrhosis

- **Vasoactive drug NOW -** terlipressin 2 mg IV q4h (then 1 mg q4h) OR octreotide 50 mcg + 50 mcg/h; continue 2-5 days
- **Antibiotics -** ceftriaxone 1 g IV daily from admission (cuts rebleed & mortality)
- **Endoscopy ≤ 12 h -** band ligation (oesophageal) · cyanoacrylate glue (gastric)
- **Uncontrolled -** balloon tamponade (Sengstaken) or removable oesophageal stent as a BRIDGE
- **Pre-emptive TIPS < 72 h -** Child-Pugh C < 14 or B with active bleeding

NON-VARICEAL

peptic ulcer commonest

- **Endoscopic haemostasis -** clips or thermal PLUS adrenaline injection for active bleeding / visible vessel
- **PPI -** IV PPI; high-dose infusion 72 h AFTER endoscopic therapy for high-risk stigmata
- **Do not delay scope for PPI -** pre-endoscopy PPI does not replace endoscopy
- **Rebleeding -** repeat endoscopy; then interventional radiology (embolisation) or surgery
- **Address the cause -** test & treat H. pylori; stop NSAIDs; review antiplatelets / anticoagulants

RISK & TRANSFUSION: Glasgow-Blatchford 0-1 → consider outpatient management. Restrictive transfusion (Hb 70-80 g/L) improves survival - over-transfusion raises portal pressure and rebleeding. Platelets > 50, correct coagulopathy.

COMMON CAUSES

- Peptic ulcer (commonest) · gastric / duodenal erosions
- Oesophageal / gastric varices · portal hypertensive gastropathy
- Mallory-Weiss tear · oesophagitis
- Malignancy · Dieulafoy lesion · angiodysplasia · aorto-enteric fistula

DO NOT MISS

- **Ongoing bleed -** haemodynamic instability despite resuscitation - back to endoscopy / IR
- **Aorto-enteric fistula -** prior aortic graft + GI bleed - CT + vascular surgery
- **Coagulopathy / drugs -** reverse anticoagulants (see #19); hold antiplatelets after discussion

DRUG DOSES: terlipressin 2 mg IV q4h → 1 mg q4h · octreotide 50 mcg bolus + 50 mcg/h · ceftriaxone 1 g/day · PPI (omeprazole 80 mg then 8 mg/h, or 40 mg BD) · reverse anticoagulants (see #19).

SCORES & REBLEEDING

GLASGOW-BLATCHFORD

Pre-endoscopy risk. Score 0-1 → very low risk, consider outpatient management.

ROCKALL

Post-endoscopy score for rebleeding and mortality; guides level of care.

REBLEEDING

Repeat endoscopy → interventional radiology (embolisation) or surgery; TIPS for variceal.

SECONDARY PREVENTION: variceal → non-selective beta-blocker (carvedilol / propranolol) + banding programme. Non-variceal → PPI, test & eradicate H. pylori (confirm cure), review NSAIDs / antiplatelets / anticoagulants.

PEARLS & PITFALLS

- Treat any cirrhotic GI bleed as variceal until endoscopy: vasoactive drug + antibiotics from the door.
- Endoscopy is the treatment; resuscitate and correct coagulopathy first, then scope within 12 hours.
- Restrictive transfusion (Hb 70-80) beats liberal - more blood means more portal pressure and rebleeding.
- Consider early / pre-emptive TIPS in high-risk variceal bleeds (Child C, or B with active bleeding).

References: Baveno VII 2022 (portal hypertension) · ESGE Non-variceal UGIB 2021 · NICE Acute UGIB.

Educational aid; verify doses against local protocol and patient factors.