Out of hours Emergency GI bleeding (COVID)

From the morning of 27.3.20 the formal emergency out of hours GI bleed rota will be suspended until further notice (this includes overnight and at weekends). Daily weekday endoscopy CEPOD lists will be running at UHW and UHL (please ensure relevant patients are kept NBM).

In cases of **significant sustained** upper GI bleeding the upper GI surgical team are happy to be contacted if resident on call (this should ideally be consultant to consultant referral). If not rostered or available please contact the Interventional Radiologist on call to consider a CT angiogram +/- embolization.

Management advice

All patients

- Large bore IV access (x2 if shocked)
- Check FBC, U&E, LFT's, coagulation profile, Group & Save, if significant bleed Cross match 4 to 6 units blood.
- IV fluids to maintain systolic BP > 110
- Transfuse blood if Hb <80gm/L or ongoing GI blood loss and haemodynamic instability
- Transfuse platelets when count < 60 x 10^9/L.
- If PT > 17sec or INR >1.5, correct with Vitamin K (10mg IV bolus & continue for consecutive 2 days) +/- FFP. Discuss with haematology re Beriplex if patient on warfarin
- **AIM FOR TARGET Hb ≈ 80 gm/L; PLATELETS 60 x 10^9/L and INR <1.5**
- Start a PPI. If significant bleed then IV bolus Omeprazole 80mg bd and when bleeding has stopped convert to oral e.g. Lansoprazole 30mg bd (NB: can start oral PPI if less significant bleed).
- Stop Aspirin, Clopidogrel, Prasugel, Ticagrelor, Dipyridamole, Apixiban, Dabigatran and Rivaroxaban at initial assessment. Need to consider risks and benefits of continuing these when bleeding stops on case-by-case basis, may need to discuss with cardiologist etc.

Suspected acute variceal haemorrhage e.g. liver disease (as above plus…)

- Do not over transfuse as this increases portal pressure and worsens bleeding coagulopathy. If 3-4 units blood transfusion is planned / required then give 2 units RCC and 2 units FFP (alternate blood FFP) aiming for target SBP 100mmHg
- Start IV Terlipressin 2 mg stat dose then 2 mg QDS (for next 3 to 5 days). Consider reduced dose Terlipressin 1mg or 0.5mg qds in IHD or PVD. Patients should be examined daily to look for stigmata of peripheral ischaemia (fingers/toes)
- Also give IV Cefotaxime 2 gm TDS for 5 days
- Prescribe regular high dose lactulose +/- phosphate enemas to ensure BO 2-3 times/day to reduce risk of hepatic encephalopathy.
- Sengstaken tubes are only to be placed in intubated patients under endoscopic guidance or with X-ray screening. These are very rarely required with Terlipressin treatment. Patient requiring Senstaken tube insertion are usually nursed on HDU/ITU.

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