Evening Medical Update: Getting to grips with Gastroenterology
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Acute upper gastrointestinal bleeding: initial assessment and management – Dr Sarah Hearnshaw, Consultant Gastroenterologist, Newcastle-upon-Tyne Hospitals NHS Foundation Trust

If a patient is still bleeding despite medical treatment given in the ED (fluid resuscitation etc.), isn't it prudent to do an OGD immediately and arrest the bleeder? Do you have to wait 10 hours?

Thank you. Yes – of course. If the patient fails to respond to initial resuscitation and has been adequately managed medically (e.g. coagulation corrected, pre endoscopic treatment for varices etc.) then absolutely early endoscopy is indicated. The message behind the slide was that these things must be done first and only then should endoscopy be requested. There are no "rules" about how long you should or shouldn't wait and every patient is different. I think common practice previously was always just to turn the tap off and get straight to endoscopy (or theatre) like in ATLS or major trauma patients – but in fact the evidence is that in AUGIB the pre endoscopy care is the bit that matters most. Absolutely do not wait 6 hours in unstable patients who continue to bleed despite the above – but do not go straight to OGD without the initial resuscitation and medical management being done first. Hope that makes sense!

If someone is hemodynamically unstable in ED with difficult resuscitation as ongoing bleeding, how would endoscopy be approached at this point? As timings are 6-12 hours provide better outcomes

Thank you – yes – better outcomes generally by ensuring resuscitation and medical management has been initiated. And all reversible causes reversed (terlipressin for varices, vit K for warfarin etc.). The paper referenced does not say all patients must wait – clearly some cannot if they are continuing to bleed despite resuscitation - they absolutely should go to endoscopy early. There are no rules – it is decided on a patient by patient basis. It is of course likely that the most sick who are bleeding most and failing to respond to resuscitation will be scoped earlier and their outcomes will be worse because they are the most sick etc. etc. hence the J shaped curves.

This patient had HB of 77 - why was she then transfused 1 unit in the example case?
Thank you – she had cardiovascular disease (IHD) on clopidogrel hence being threshold of 80g/dl instead of standard 70g/dl. Of course it is important to check the Hb after initial resuscitation as often it will reduce once haemodynamics are corrected with IVT.

When can a patient start to eat following a scope?
Good question! The answer for general OP or IP non bleeders is "once fully awake or one hour after throat spray administered".

No evidence based answer really in AUGIB. Generally if the endoscopist is happy haemostasis is achieved or it was a low risk bleed that did not need therapy - and low risk of needing another scope then encourage food once fully awake and or throat spray has worn off (we say an hour after administered). Food is a good antacid.

If endoscopist is *not* certain or non-specific about haemostasis and writes as such on the report either ask them directly or stick with clear fluids for first 6-12 hours then food if remains stable. Most will say "relook tomorrow – keep starved" or "high risk re-bleeding – for second scope then consider IR" etc. In this case keep off food.

For varices we tend to wait a bit longer and start with drinks / soft sloppy food for the first 24 hours.

Hope that helps!