Forenames

Lastname

Hospital No.

D.O.B.

St Helens and Knowsley Teaching Hospitals NHS Trust

SDEC management of acute lower gastrointestinal bleeding*

***Bleeding into the bowel distal to the ligament of Treitz**

NB: This pathway is designed to be used as a supplement to the Trust

PATIENTS MUST NOT BE AMBULATED FROM ED WITHOUT REVIEW ON WARD

History Bright or dark blood per rectum, maroon coloured stool or blood mixed in with stool, clots per rectum or passage of melaena without haematemesis (ACPGBI audit LGIB definition 2016)

Abdominal examination including digital rectal examination

↓

Proctoscopy or rigid sigmoidoscopy

↓

Full blood count, coagulation screen and routine biochemistry.

↓

Medication review[1]

↓

Shock index <1

↓

Oakland score <8[2]

↓

Consider SDEC management

EXCLUSION CRITERIA; Clinically significant bleeding associated with systolic blood pressure <100mmHg, heart rate ≥ 100 or requiring transfusion

↓

If suitable for SDEC: Discharge with appropriate documentation and safety-netting advice. Generate ICE discharge and give copy to patient. Book OP urgent flexible sigmoidoscopy/colonoscopy as indicated. Arrange follow up with on call consultant.

[1]Continue low-dose aspirin for secondary prevention of vascular events in patients with lower gastrointestinal bleeding in whom haemostasis has been achieved or are considered to have stopped bleeding spontaneously. Stop other non-steroidal anti-inflammatory drugs (including cyclooxygenase-2 inhibitors) during the acute phase.

[2]https://www.mdcalc.com/oakland-score-safe-discharge-lower-gi-bleed

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NOTES:

	Score component value
Age (years)	
<40	0
40–69	1
>70	2
Sex	
Female	0
Male	1
Previous lower gastrointestinal bleeding admission	
No	0
Yes	1
DRE findings	
No blood	0
Blood	1
Heart rate (bpm)	
<70	0
70–89	1
90–109	2
>110	3
Systolic blood pressure (mm Hg)	
50–89	5
90–119	4
120–129	3
130–159	2
>160	0
Haemoglobin (g/dL)	
36–69	22
70–89	17
90–109	13
110–129	8
130–159	4
>160	0

DRE=digital rectal examination.

Table 2: A score to predict the safe discharge of patients presenting with acute lower gastrointestinal bleeding

Clinical guideline: Patients presenting with lower gastrointestinal bleeding (LGIB) are stratified as unstable or stable (unstable defined as a shock index >1). Stable bleeds should then be categorised as major or minor, using a risk assessment tool such as the Oakland score and patients presenting with a minor self-terminating bleed (such as those with an Oakland score ≤8 points), with no other indications for hospital admission can be discharged for urgent outpatient investigation. Patients with a major bleed should be admitted to hospital for colonoscopy on the next available list. If a patient is haemodynamically unstable or has a shock index (heart rate/systolic BP) of >1 after initial resuscitation and/or active bleeding is suspected, CT angiography provides the fastest and least invasive means to localise the site of blood loss before planning endoscopic or radiological therapy. As LGIB associated with haemodynamic instability may be indicative of an upper gastrointestinal bleeding source, an upper endoscopy should be performed immediately if no source is identified by initial CT angiography (CTA). If the patient stabilises after initial resuscitation, gastroscopy may be the first investigation. Where indicated, catheter angiography with a view to embolisation should be performed as soon as possible after a positive CTA to maximise chances of success. No patient should proceed to emergency laparotomy unless every effort has been made to localise bleeding by radiological and/or endoscopic modalities, except under exceptional circumstances . In patients who are clinically stable but may need red blood cell (RBC) transfusion, restrictive RBC thresholds (Hb trigger 70g/L and a Hb concentration target of 70–90g/L after transfusion) should be used, unless the patient has a history of cardiovascular disease, in which case a trigger of 80g/L and a target of 100g/L should be used. Recommend interrupting warfarin therapy at presentation. In cases of unstable gastrointestinal haemorrhage, anticoagulation should be reversed with prothrombin complex concentrate and vitamin K. For patients with low thrombotic risk, warfarin should be restarted at 7 days after haemorrhage. In patients with high thrombotic risk (i.e., prosthetic metal heart valve in mitral position, atrial fibrillation with prosthetic heart valve or mitral stenosis, <3 months after venous thromboembolism), we recommend that low molecular weight heparin treatment be considered at 48hours after haemorrhage. Aspirin for primary prophylaxis of cardiovascular events should be permanently stopped but aspirin for secondary prevention is not routinely stopped. If it is stopped, it should be restarted as soon as haemostasis is achieved. Dual antiplatelet therapy with a P2Y12receptor antagonist (clopidogrel (Plavix), prasugrel (Efient, Effient), ticagrelor (Brilinta), and cangrelor (Kengreal)) and aspirin is not routinely stopped in patients with coronary stents *in situ*, and management should be in liaison with a cardiologist. In unstable haemorrhage. recommend continuing aspirin *if the P2Y12 receptor antagonist is interrupted*. P2Y12 receptor antagonist therapy should then be reinstated within 5 days. Recommend interrupting direct oral anticoagulant therapy at presentation. Contact Haematology for advice regarding considering treatment with inhibitors (such as idarucizumab or andexanet) for life-threatening haemorrhage in patients on direct oral anticoagulants. Suggest restarting direct oral anticoagulant drug treatment at a maximum of 7 days after haemorrhage.

Doctor's Name _____ **Designation** _____

Signature _____ **Date** _____