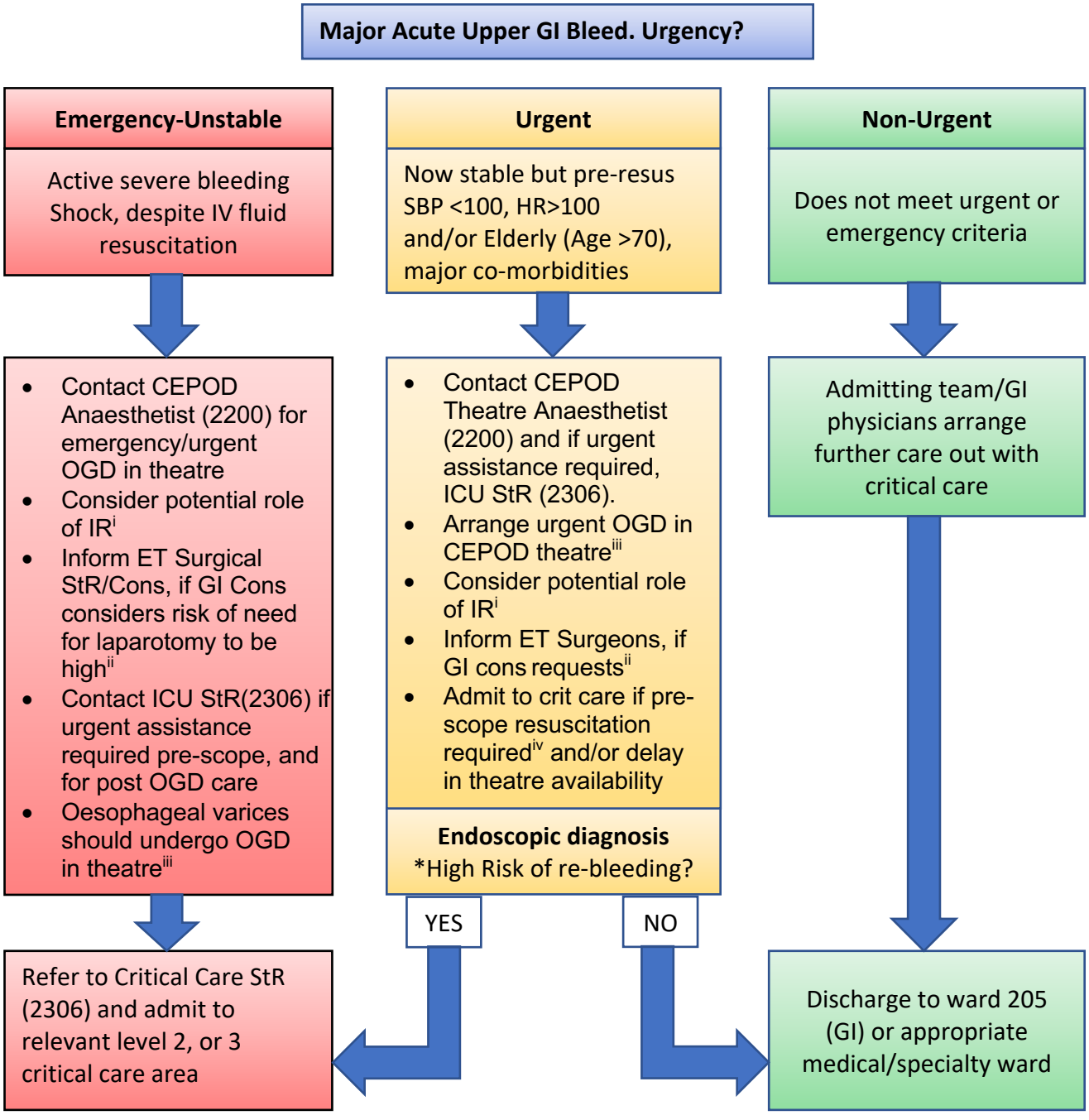
Critical Care Guidelines for the emergency management of acute upper GI bleeding and Oesophago-Gastro-Duodenoscopy (OGD)

1. Urgent/emergency endoscopy for Acute Upper GI Bleeding



- **OGD is not an aerosol generating procedure**
- Referral to Critical Care and/or ET Surgeons, should be undertaken by GI Reg (2117)/ Consultant.

***High Risk of Rebleeding Criteria:**
- Adherent clot over ulcer
- Visible vessel in ulcer
- Active bleeding
- Varices

Flow chart notes:

i) Patients most likely to benefit from IR for haemorrhage control

- Non-variceal haemorrhage (NB. TIPSS may be indicated post banding of OV)
- Failed endoscopic management
- Known lesion, potentially amenable to IR intervention
- Patient is stable enough to transfer to IR (May require GA and anaesthesia assistance)
- Risk of need for laparotomy is low (see below)
- Significant co-morbidities, which may preclude further OGD/surgery

ii) Patients at high risk of need for laparotomy (OGD must be performed in theatre)

- Uncontrolled non-variceal haemorrhage, patient too unstable for transfer to IR
- Failed endoscopic management and IR contraindicated/bleeding point not amenable to IR intervention
- Suspected perforation (de novo or iatrogenic), surgical abdomen, bleeding GIST
- GI consultant considers risk to be high

iii) Urgent OGD in Critical Care

OGD for oesophageal varices (or other acute GI haemorrhage, where the risk of need for laparotomy, is low), ***may*** be performed in 118 within dayshift hours, in selected patients, e.g. if the patient is already a critical care inpatient, intubated and staffing levels/experience levels allow. **This is at the discretion of the duty Critical Care Consultant, who must be involved in discussions.**

iv) Admission to critical care, prior to OGD

Patients who require urgent, but not emergency endoscopy, may benefit from admission to Critical Care pre-endoscopy, for resuscitation and transfusion. There is evidence that, this may improve outcome (2,3).

Further management of acute upper GI haemorrhage

- There is no role for Tranexamic acid -see HALT-It study (4)
- Adopt a restrictive post-emergency resuscitation blood transfusion strategy, that aims for a target haemoglobin between 7g/dL and 9g/dL. A higher target haemoglobin, should be considered in patients with significant co-morbidity e.g. ischaemic cardiovascular disease (1,2,6)
- PPI infusions should be administered for 72 hours post endoscopy (unless directed otherwise, by senior GI physicians) as per the Hong Kong protocol (5)
- Consider correction of coagulopathy and reversal of antiplatelets -may require specialist input from haematology (1,2,6)

2. Non-urgent endoscopy for Critical Care inpatients

Non-urgent OGD can be performed in a level 3 Critical Care area (pods 118A,118B and 116 D) for patients already in ICU, requiring procedural interventions e.g NJ tube insertion, providing the following conditions are met:

- The ICU base duty Critical Care consultant and Charge nurse, are in agreement.
- Medical and nursing staffing levels/experience are adequate for the procedure to be performed safely.
- The procedure is performed in dayshift hours.

OGD should not be performed in a level 2 Critical Care area, i.e. 116C

References

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Title: Critical Care Guidelines for Oesophago-Gastro-Duodenoscopy (OGD)	
ID	**Authors:** M Beatty, N Church
Category	**Document Version:** 4
Status: Final	**Review Date:** October 2025
Authoriser: RIE QIT team	**Date Authorisation:** September 22nd 2022
Date added to intranet	
Key words: Endoscopy, OGD, Acute upper GI haemorrhage	