Critical Care Guidelines FOR CRITICAL CARE USE ONLY



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

Major Acute Upper GI Bleed. Urgency?

Emergency-Unstable Urgent **Non-Urgent** Now stable but pre-resus Active severe bleeding Does not meet urgent or SBP <100, HR>100 Shock, despite IV fluid emergency criteria and/or Elderly (Age >70), resuscitation major co-morbidities **Contact CEPOD** Contact CEPOD Admitting team/GI Theatre Anaesthetist Anaesthetist (2200) for physicians arrange (2200) and if urgent emergency/urgent further care out with assistance required, OGD in theatre critical care ICU StR (2306). Consider potential role Arrange urgent OGD in of IRi CEPOD theatreiii Inform ET Surgical Consider potential role StR/Cons, if GI Cons considers risk of need Inform ET Surgeons, if for laparotomy to be GI cons requests highⁱⁱ Admit to crit care if pre-Contact ICU StR(2306) if scope resuscitation urgent assistance requirediv and/or delay required pre-scope, and in theatre availability for post OGD care Oesophageal varices **Endoscopic diagnosis** should undergo OGD *High Risk of re-bleeding? in theatreiii YES NO Refer to Critical Care StR Discharge to ward 205 (2306) and admit to (GI) or appropriate relevant level 2, or 3 medical/specialty ward critical care area

- 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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