Upper GI and Ulcer Bleeding

A Summary of ACG Clinical Guidelines

Risk Stratification

- Glasgow-Blatchford score (GBS) can identify very-low risk patients
- Patients classified as very-low risk (score 0-1) can be discharged with outpatient follow-up
- Decision for admission or discharge should be tailored to patient and practice setting

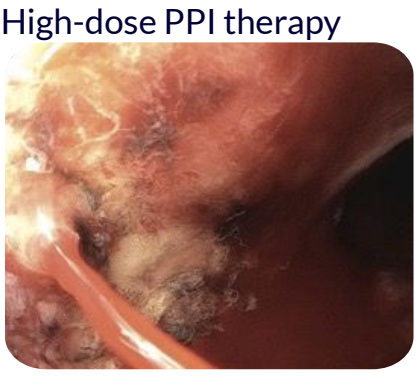
Pre-Endoscopic Therapy

- Consider erythromycin infusion prior to endoscopy
- Can ↑ visualization of index endoscopy, ↑diagnostic yield, ↓ LOS, ↓ repeat endoscopy, BUT no evidence for ↓ further bleeding or mortality
- No recommendation for or against PPI prior to endoscopy
- Patients with UGIB should undergo endoscopy within 24 hours of presentation

Forrest Classification for UGIB

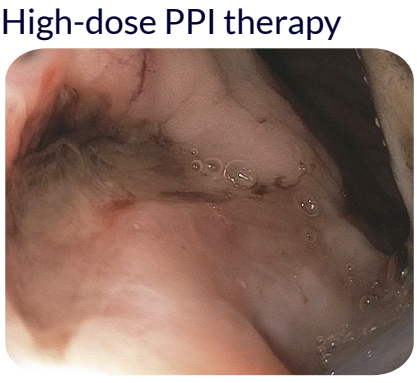
Actively Bleeding or Visible Vessel

- Endoscopic therapy
- High-dose PPI therapy



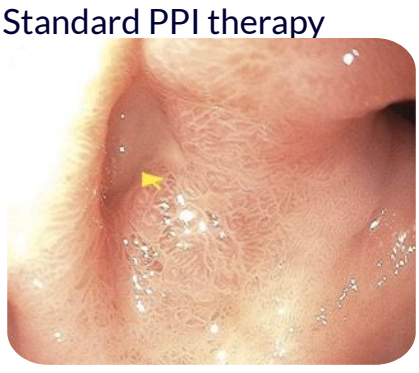
Adherent Clot

- No recommendation for or against endoscopic therapy
- High-dose PPI therapy



Flat Pigmented Spot or Clean Base

- No endoscopic therapy
- Standard PPI therapy



PPI Dosing Guide

High-Dose PPI Therapy

Continuous: 80mg bolus → 8mg/min infusion for 72hrs

OR

Intermittent: 40mg 2 to 4 times daily for 72hrs, PO if feasible

Standard PPI Therapy

PPI once daily

Transfusions

- Restrictive RBC transfusion threshold (Hgb <7g/dL) reduces further bleeding and death
- Hypotensive patients can be transfused at higher Hgb
- Threshold of Hgb <8g/dL is reasonable for those with pre-existing cardiovascular disease

Endoscopic Therapy

- UGIB due to actively spurting, actively oozing, and non-bleeding visible vessels should receive endoscopic therapy

Endoscopic Therapy: Strong Recs

- Bipolar Electrocoagulation/Heater Probe

- Thermal contact devices ↓ bleeding and mortality

- Sclerosant Injection

- Absolute ethanol injections ↓ bleeding and mortality, pilodocanol not recommended

- Epinephrine

- Monotherapy is not recommended; use in combination with another hemostatic modality

Endoscopic Therapy: Conditional Recs

- Hemoclips

- Seal underlying artery, evidence is less robust

- Argon Plasma Coagulation

- Evidence is less robust, better than no intervention

- Soft Monopolar Electrocoagulation

- Developed for ESD

- Hemostatic Powder Spray TC-325

- Limited duration of effect, expensive, poor evidence as monotherapy

- Over the Scope Clip

- Preferred in patients with recurrent bleed or refractory bleeding ulcers

Post-Endoscopy Management

- ↓ intragastric acid → ↑ clot formation and stability
- Initial bolus PPI at 80mg ↓ intragastric acid, especially in Western population
- IV PPI has more rapid onset
- High-dose PPI for ≥ 3 days after endoscopic therapy ↓ further bleeding and mortality
- UGIB due to high-risk ulcers who received endoscopic therapy should receive BID PPI for 2 weeks post index endoscopy

Recurrent GI Bleeding Post-Endoscopy

- Repeat endoscopy → transcatheter arterial embolization (TAE) or surgery
- Repeat endoscopy associated with less complications than surgery
- No RCTs comparing repeat endoscopy vs TAE
- Surgery after failed endoscopy and unsuccessful TAE

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All endoscopic images are from cases performed at either Grady Memorial Hospital or Emory University Hospital

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