



AAST Acute Care Surgery Didactic Curriculum

Upper GI Bleeding

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Upper GI Bleeding

Highlights:

- UGIB with low Glasgow-Blanchard score: DC from ED
- UGIB should undergo resuscitation, transfusion if Hgb < 7, erythromycin prior to endoscopy to clear the stomach of any clot
 - Balanced crystalloids are preferred over saline
- UGIB should undergo endoscopy within 24h of presentation
- Standard vs high dose PPI depend on ulcer appearance by Forrest classification
- Recurrent UGIB should undergo repeat EGD, followed by angioembolization, with surgery as a last resort treatment option
 - If recurrent bleed, embolization is associated with higher rebleeding, but lower mortality and morbidity, and shorter hospital LOS when compared with surgery

Acute Variceal bleed

Highlights:

- Varices are present in approximately 1/3 of patients with compensated cirrhosis, and approximately 2/3 of patients with decompensated cirrhosis
- Pharmacologic treatment: splanchnic vasoconstriction (vasopressin or terlipressin) + inhibition of GI secretory hormones (somatostatin or octreotide)
- Endoscopy is recommended within the first 12 hours. For active bleeding or rebleeding, TIPS must be considered
- In an acute bleed, initiation of pressors with a goal MAP of 65 is recommended, though permissive hypotension may enable endogenous splanchnic vasoconstriction, which may reduce portal hypertension
- Restrictive transfusion strategy for Childs A-B is appropriate, with a target Hgb of 7-9 g/dL
- Prophylactic antibiotics must be started in a cirrhotic with a suspected variceal bleed
 - Presence of infection is an independent predictor of both rebleeding and mortality
- Airway protection must be considered as aspiration pneumonia is a common cause of morbidity and mortality

- If endoscopic band ligation or sclerotherapy is ineffective, must consider tamponade with a balloon (Sengstaken-Blakemore tube) or esophageal stent, followed by rescue transjugular intrahepatic portosystemic shunt (TIPS) or devascularization surgery