

Hi doctor, can you come
and see my patient, she's
just had a coffee ground
vomit....

Dr Rhona Hurley, FY2



What now?

- Ask for more information
 - What might you ask?
 - Do you have enough information about this patient?
- GO AND SEE THE PATIENT!!!!!!
 - You don't know what you're dealing with
 - Don't just say 'recheck obs 1 hour/monitor'
 - Hard when busy on call
 - Prioritisation



ABCDE

- Stick with this, helpful – can be used for documentation
- Patients can have multiple problems!
- If person capable can talk to them while doing this for history
- Bring a nurse with you
- Primary aim – assess blood loss, shock
- Secondary aim – underlying cause
- A – patent or not?
- B – RR, SpO2, Trachea central, colour of patient, resonant to percussion, breath sounds?
 - CXR – rule out perforated oesophagus

ABCDE continued

- C
 - Pulse rate & rhythm, BP, CRT
 - ECG – anaemia can drive ischaemia and AF
 - Heart sounds
 - Postural hypotension – may indicate blood loss of 20% or more
 - IV access
 - Preferably x 2 and large bore
 - BUT SOME ACCESS IS BETTER THAN NO ACCESS
 - Bloods – which ones?
 - Do you want to wait for lab Hb?
 - Hang IV fluids if in any doubt of condition of patient
 - If concerned – MET call/Major haemorrhage protocol
 - FBC/platelets
 - Get help!

Class of haemorrhagic shock

	I	II	III	IV
Blood loss (mL)	Up to 750	750–1500	1500–2000	> 2000
Blood loss (% blood volume)	Up to 15	15–30	30–40	> 40
Pulse rate (per minute)	< 100	100–120	120–140	> 140
Blood pressure	Normal	Normal	Decreased	Decreased
Pulse pressure (mm Hg)	Normal or increased	Decreased	Decreased	Decreased
Respiratory rate (per minute)	14–20	20–30	30–40	> 35
Urine output (mL/hour)	> 30	20–30	5–15	Negligible
Central nervous system/ mental status	Slightly anxious	Mildly anxious	Anxious, confused	Confused, lethargic

A note on IV fluids..



ABCDE

- D – GCS/AVPU and blood glucose
 - Also note confusion
- E – Exposure
 - Brief feel of abdomen & listen for bowel sounds
 - Any obvious stigmata of liver disease
 - Check around for any signs of haematemesis or melaena
 - PR necessary for occult bleeding
 - Check drug kardex
 - Fluid balance review
 - Consider catheter
 - AXR

After this

- If at all concerned get help ASAP
- ALWAYS better to call for 'nothing' than to not call for 'something'
- More definitive management involves interventions like terlipressin/OGD
- These patients can become very unwell very quickly
- May need HDU/ITU
 - Not decisions for you!
- DO NOT BE A HERO

UGI bleeds

Frank bleeding



Coffee ground vomiting



UGI vs LGI bleed

Melaena – UGI



PR bleeding



History

- May help point to cause
- Abdominal pain
- Chest pain
- Dyspepsia symptoms
- Drug history
- Weight loss/anorexia
- Jaundice
- Alcohol/drug history
- Notes review
- Remember your patient – very frightening experience

Why do hospital inpatients get UGI bleeds?

- Stroke/MI patients – aspirin/clopidogrel/warfarin
- NSAIDS - PUD
- COPD/Asthmatics – prednisolone - PUD
- VTE - rivaroxaban
- Post-operative – stress ulcers
- Liver disease – varices
- Post AAA repair - aorto-enteric fistula
- Gastric cancer/oesophageal cancer
- Everyone – LMWH

Potential complications

- CAD patients – ischaemia due to hypoxaemia
- Volume overload from over-transfusion/fluid resuscitation
 - Renal failure/heart failure
 - May need invasive monitoring eg central line during resuscitation
- Aspiration
 - Hepatic encephalopathy
 - Stroke
 - Dementia

Case

- 4am bleep – FY1 covering GI ward/geriatrics at night
- Across the hospital
- 'Just to let you know, one of the patients has just vomited up a bit of blood....maybe an eggcup full...but they are fine'
- What else do you want to know?
- Turn up to ward and nurses away in handover

Case

- 48-year-old male
- Original reason for admission – variceal bleed requiring HDU admission. Numerous previous bleeds. Notes state very poor prognosis, not for further endoscopy, terlipressin only.
- Observations – BP 90/50 from 110/70, HR 110, RR 25 otherwise OK

A – patent

B – RR 18, SpO2 97%, No abnormal chest findings

C – Pale, clammy, tachycardic. Pulse thready. ECG long-standing T-wave inversion V1-V3. BP 85/60, HR 120, RR 30.

D – Alert, BM normal

E – Caput medusae, distended abdomen, jaundiced sclerae. Abdomen non-tender. Not passed urine all day.

Case

- How unwell is this man?
- Can you cope on your own?
- What do you need to do now?
 - Can be difficult to get people to DO stuff
 - Clear communication needed as to urgency
- Can you wait for cross-matched blood?
- Suitable ward patient?

Summary

- GI bleeds are common in hospital inpatients
- Many causes
- Can be frightening
- Basic management REALLY helps
- Always GROUP + SAVE
- Get help quickly
- Make sure the things you want done are DONE
- Don't assume you can get an accurate picture of the patient from the phone call

Any questions?

