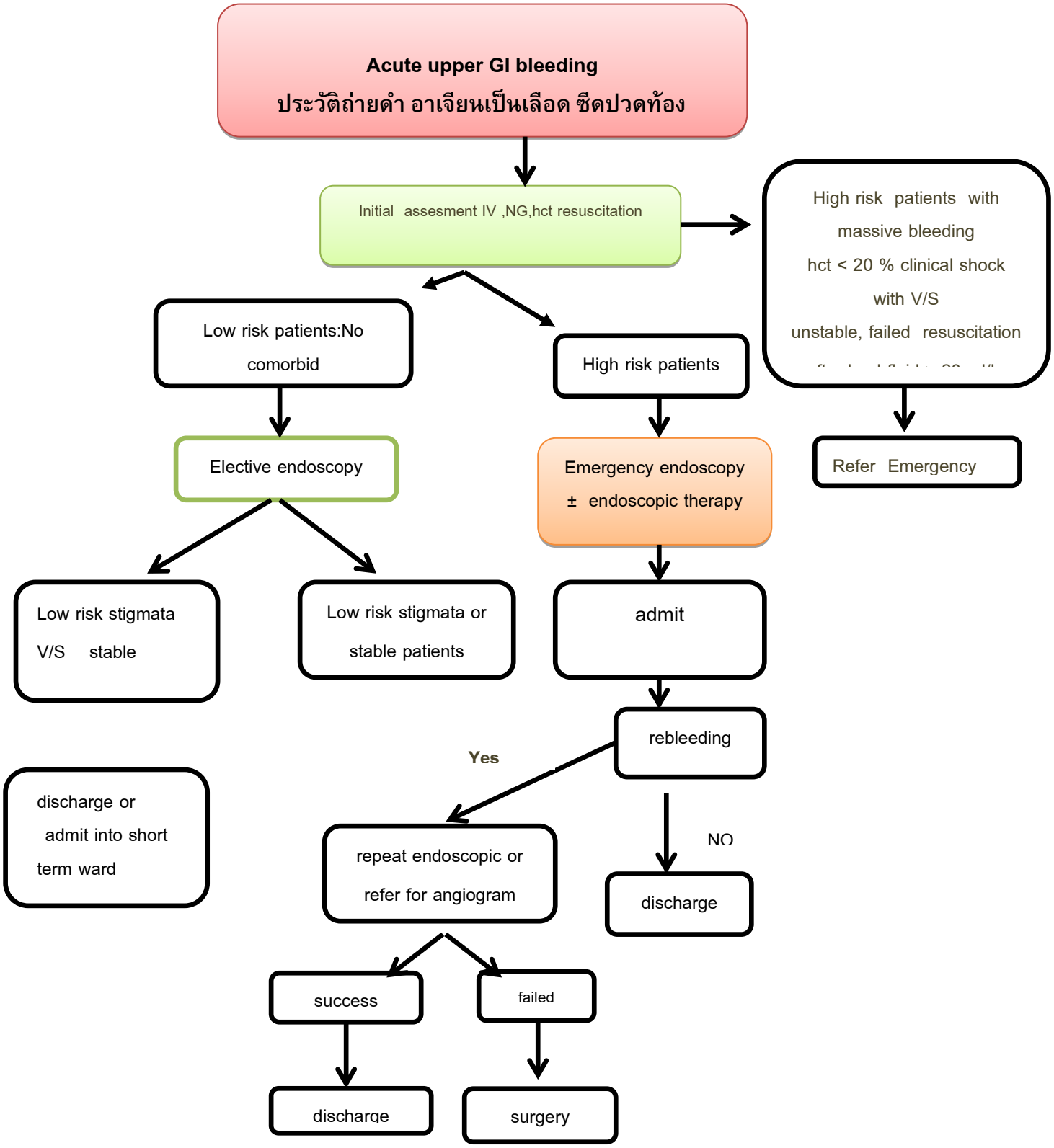
Clinical Practice Guideline : acute upper gastrointestinal bleeding



การคิดคะแนนเพื่อประเมินความเสี่ยงต่อการเกิดภาวะแทรกซ้อนโดยใช้ Rock all score เป็นแนวทาง

ค่าคะแนน				
ค่าตัวแปร	0	1	2	3
อายุ (ปี)	< 60	60-79	> 79	-
ภาวะช็อค	No shock	Tachycardia	Hypotension	Shock
Comorbidity	No	-	CHF, IHD, major co-morbidity	Renal failure, live failure, disseminated malignancy
การวินิจฉัย	MWT, no, lesion no SRH	All other diagnosis	Malignancy of UGI-tract	-
Major stigmatata of recent hemorrhage	None	-	Blood in UGI tract, adherent clot, visible vv, spurting vv.	-

vv: vessel, MWT: Mallory-Weiss tear, SRH: stigmata of recent hemorrhage, UGI: upper gastrointestinal bleeding, IHD: ischemic heart disease, CHF: congestive heart failure

Low risk คือคะแนน < 3 mortality 12%

High risk คือ คะแนน ≥ 4 mortality 20%

ลักษณะแผลที่ทำให้เกิดเลือดออกในทางเดินอาหารส่วนต้นกับส่วนโอกาสเลือดออกซ้ำจากแผล

ลักษณะแผล	โอกาสเลือดออกซ้ำจากแผลหากไม่ได้รับการทำ therapy (ร้อยละ)
Active arterial (spurting) bleeding	100
Non-bleeding visible vessel (“pigmented protuberance”)	50
Non-bleeding adherent clot	**30-35**
Ulcer oozing (without other stigmata)	10-27
Flat spots	< 8
Clean-based ulcers	< 3

Care Map for UGIB

กิจกรรม	วันแรก	วันที่ 2-7
Diagnosis	❀	Resuscitation • Identification of bleeding site • Cessation of active bleeding • Prevention of recurrence of bleeding
	❀	
Investigation	Endoscope indication /contraindication Indications: • Included all patients who were evaluated for small bowel pathology • Diagnosis • Treatment • Surveillance: Polyposis syndrome Relative contraindications: • Adhesion bands from prior surgery • Underlying disease: Crohn's disease • Large esophageal varices (antegrade approach) Absolute contraindications: • Perforation • Not suitable condition: Shock Endoscopy should be performed within 24 hours in patients with significant bleeds. Patients with Rock all scores of 0 or 1 may be candidates for immediate (see over) discharge and outpatient endoscopy	Patients at low risk after endoscopy can be fed within 24 hours. • D2. Most patients who have undergone endoscopic hemostasis for high-risk stigmata should be hospitalized for at least 72 hours thereafter. • D3. Seek surgical consultation for patients for whom endoscopic therapy has failed.

	the following day, depending on local policy. After adequate resuscitation, urgent endoscopy should be performed in patients with shock, suspected varices or with continued bleeding. Endoscopy can detect the cause of the hemorrhage in 80% or more of cases. In patients with a peptic ulcer, if the stigmata of a recent bleed are seen (i.e. a spurting artery, active oozing, fresh or organized blood clot or black spots) the patient is more likely to re-bleed. Calculation of the post-endoscopy Rock all score gives an indication of the risk of re-bleeding and death.	
Medicagtion	● Antibiotic Prophylaxis Antibiotic prophylaxis after endoscopy for UGIB - Norfloxacin 400 mg BID X 7 days after endoscopy or iv. Ciprofloxacin* - In patients with advanced cirrhosis iv. ceftriaxone (1gm/day) may be preferable particularly in centers with high prevalence of	

	quinolone-resistant organisms* ● After diagnosis at endoscopy, intravenous Omeprazole 80 mg followed by infusion 8 mg/h for 72 hours should be given to all ulcer patients as it reduces re-bleeding rates and the need for surgery. ● Chronic peptic ulcer. Eradication of H. pylori is started assoon as possible (see p. 261). A PPI is continued for 4 weeks to ensure ulcer healing. Eradication of H. pylori should always be checked in a patient who has bled and long-term acid suppression given if HP eradication is not possible. If bleeding is not controlled, surgery with ligation of the bleeding ● vessel is performed to control hemorrhage.	
Treatment	Management of acute gastrointestinal bleeding ■ History and examination. Note co-morbidity ■ Monitor the pulse and blood pressure half-hourly ■ Take blood for hemoglobin, urea, electrolytes, liver	

	biochemistry, coagulation screen, group and cross-matching (2 units initially) ■ Establish intravenous access – 2 large bore i.v. cannular ; central line if brisk bleed ■ Give blood transfusion/colloid if necessary. Indications for blood transfusion are: (a) SHOCK (pallor, cold nose, systolic BP below 100 mmHg, pulse ☐ (b) hemoglobin ☐ patients with recent or active bleeding ■ Oxygen therapy ■ Urgent endoscopy in shocked patients/liver disease ■ Continue to monitor pulse and BP ■ Re-endoscope for continued bleeding/hypovolemia ■ Surgery if bleeding persists	
D/C	*Discharge policy* The patient's age, diagnosis on endoscopy, co-morbidity and the presence or absence of shock and the availability of support in the community should be taken into consideration. In general, all patients who are hemodynamically stable and	Suggest refer Failure Endoscopic Therapy • Risk factors associated with treatment failure with combination injection therapy and heater probe; • Hypertension • Hb < 10 g/dL • Fresh blood in the stomach • Ulcer with active bleeding • Ulcer > 2 cm

	have no stigmata of recent hemorrhage on endoscopy (Rock all Score pre-endoscopy 0, post-endoscopy ≤ 1) can be discharged from hospital within 24 hours. All shocked patients and patients with co-morbidity need inpatient observation.	Indication for sX 1. Continued active bleeding and unable to perform endoscopy 2. Require blood transfusion > 6 units/24 hr 3. Failure of endoscopic treatment 3. Re-bleeding after successful endoscopic treatment