

## GASTROINTESTINAL BLEED

### Management of GI bleed in ICU patients

Significant stress ulcer bleeding occurs in 2-6% of the critically ill patients.

- Determine whether it is a haemodynamically stable bleed or unstable bleed  
and whether it is an upper or lower GI bleed (in general, malaena and coffee ground aspirates indicates upper GI bleed, fresh blood per rectum indicates lower GI bleed)
- For haemodynamically unstable bleed:
  - 1. check if able to protect airway (if not already intubated)
  - 2. establish wide bore IV cannula (if not already present)
  - 3. IV fluids
  - 4. cross match ( if not already available)
  - 5. correct platelets, clotting abnormalities, stop aspirin and LMWH if patient is on these drugs
  - 6. call GI on call
  - 7. Change from H2 antagonist to proton pump inhibitor (PPI). H2 antagonists do not reduce the incident of rebleeding from duodenal ulcer whereas PPIs have been shown to reduce the risk of rebleeding and surgery in this group of patients
  - 8. if ulcer small, and bleeding easily controlled, start PPI eg omeprazole (losec) or pantoprazole (pantoloc) at 40 mg IV bd. If giant ulcer, rebleed, then follow PWH protocol: omeprazole 80 mg IV stat followed by 8 mg/h infusion for the next 72 hours
  - 9. Surgery if bleeding persists despite endoscopic and pharmacologic interventions
- For haemodynamically stable bleed  
Management essentially same as above but one may not need to perform endoscopy 'stat'.  
Be prepared patient may suddenly become unstable

The other groups of GI bleed patients you may encounter are consultations from the ward or endoscopy unit. The patient may be very unstable and the environment hostile. Please inform your seniors and get help early.

### Management of Variceal Bleed

(torrential bleed may occur)

- principle of resuscitation same  
protect airway, wide bore IV cannula, fluid resuscitation, blood products
- involve GI on call team early

- urgent OGD to stop bleeding and to look for other causes of bleeding
- bleeding may be very torrential and need Sengstaken tube insertion ( by this time the patient should have been intubated)
- Octreotide or vasopressin can be considered
  - Octreotide: reduces splanchnic blood flow and portal pressure
    - Bolus 25-100ug IV
    - Infusion 25-50ug/hour for a maximum of 5 days
  - Vasopressin: potent vasoconstrictor that reduces splanchnic blood flow and portal pressure
  - Adverse effects include hypertension, myocardial ischaemia, electrolyte abnormalities due to ADH activity
  - 0.4-1.0U/minute
  - Concurrent GTN infusion may be necessary to reduce side effects of systemic vasoconstriction
- TIPPS/ Surgical shunts may be considered