Approach to GI Bleeding

ABDOMINAL

98.6% KEY DECISION RULE
Glasgow-Blatchford score ≤1[1,5]
sensitivity for intervention or death; score ≤1 suits outpatient care

Hematemesis, coffee-ground emesis, melena or hematochezia

→ Two large-bore IVs; shock index, rectal exam; CBC, INR, urea, creatinine, crossmatch[12]

→ **Unstable, cirrhosis or antithrombotic?**

Yes →

Unstable: resuscitate, ICU, then EGD or CTA[1,3,12]

- Shock (SI >1 or SBP <90): RBC now[3,12]
- Hb <70 g/L (<80 if CV disease): transfuse[1,2,12]
- Large hematemesis or ↓LOC: intubate[7,12]
- Cirrhosis: octreotide, ceftriaxone, EGD ≤12 h[7]
- Anticoagulant: hold; warfarin: PCC, not FFP[9]
- Cardiac ASA: keep; no vit K, no TXA[9,10]

→ **Hematochezia + shock: EGD if upper possible, else CTA**[3,12]

If stable: where is the source?

	Upper, nonvariceal most UGIB	**Variceal** cirrhosis	**Lower GI** colon	**Small bowel** EGD, colo –
CAUSES	• Peptic ulcer: NSAIDs, H. pylori • Esophagitis, gastritis, Mallory-Weiss • **Aortoenteric fistula (aortic graft)**	• **Esophageal varices** • **Gastric varices** • Portal hypertensive gastropathy	• Diverticular bleed (30–65%)[12] • Hemorrhoids, angioectasia, colitis • Colorectal cancer; post-polypectomy	• Angioectasia; Heyde (with AS) • Crohn, NSAID ulcers, tumour • Meckel diverticulum if young
CLUES	• Melena on exam (LR 25)[4] • Urea:Cr >0.12 (BUN:Cr >30): LR 7.5[4] • NSAIDs or aspirin; epigastric pain	• Known cirrhosis or heavy alcohol use • Ascites, spider angiomas, low platelets	• Painless hematochezia; older adult • Clots in stool: not upper (LR 0.05)[4] • Hematochezia + shock: 10–15% upper[12]	• Normal EGD and colonoscopy[11] • Iron deficiency; recurrent melena
WORKUP	• Blatchford ≤1: outpatient EGD[1,5] • Others: EGD within 24 h[1,2] • Aortic graft: CTA, vascular surgery[12]	• EGD within 12 h of presentation[7] • INR, bilirubin, albumin: Child-Pugh	• Oakland ≤8: outpatient colonoscopy[3,8] • Admitted: colonoscopy after prep[3] • Brisk bleed: CTA, not urgent colo[3]	• Second-look EGD or colonoscopy[11] • Capsule endoscopy first line[11] • CT enterography if stricture risk[11]
MANAGE	• Pre-EGD: erythromycin ± IV PPI[1,12] • High-risk ulcer: scope, IV PPI ×3 d[1,2] • PPI BID ×2 wk; H. pylori, retest if neg[1,2]	• Octreotide 2–5 d; ceftriaxone 1 g/d[7] • Band ligation; avoid over-transfusing[6,7] • TIPS ≤72 h: Child C10–13 or B+active[7]	• Most stop on their own • Endoscopic clips or coagulation[3] • CTA positive: embolize; surgery last[3]	• Deep enteroscopy to treat lesion[11] • Iron; octreotide for angioectasia[12]

Stethopedia
stethopedia.ca/approach/gi-bleeding

Evidence [1] Laine 2021, Am J Gastroenterol [2] Barkun 2019, Ann Intern Med [3] Sengupta 2023, Am J Gastroenterol [4] Srygley 2012, JAMA [5] Stanley 2017, BMJ [6] Villanueva 2013, N Engl J Med [7] de Franchis 2022, J Hepatol [8] Oakland 2017, Lancet Gastroenterol [9] Abraham 2022, Am J Gastroenterol [10] HALT-IT 2020, Lancet [11] Gerson 2015, Am J Gastroenterol [12] Manual 2024–25, pp. 67–68