Nonvariceal Upper Gastrointestinal Bleeding

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KEYWORDS

• Nonvariceal upper gastrointestinal bleed • Blatchford score • Rockall score
• Proton pump inhibitor • Nonsteroidal antiinflammatory drugs • Peptic ulcer disease
• Endoscopy

KEY POINTS

- Nonvariceal upper gastrointestinal bleeds are a medical emergency.
- The Blatchford and Rockall scores are useful risk stratification models.
- Nonvariceal upper gastrointestinal bleeding requires prompt assessment of respiratory status and hemodynamics, with prompt fluid resuscitation and blood product transfusions if necessary, and timely endoscopy.
- Proton pump inhibitors are the mainstay of pharmacologic treatment in nonvariceal upper gastrointestinal bleeding.
- Management is predicated on endoscopic findings and subsequent diagnosis with endoscopic therapy.

INTRODUCTION

Nonvariceal upper gastrointestinal bleeding (NVUGB) often requires aggressive care and monitoring in the critical care setting. Several risk factors and models have been identified to guide clinical practice. Clinical features, including history and physical examination, provide important cues to ascertain a diagnosis and institute treatment. Physicians should be adept at developing a focused differential diagnosis to coordinate symptoms with disease processes. The primary goal is hemodynamic stability with fluid resuscitation and blood or blood product transfusions if warranted. Once this primary goal is achieved, pharmacologic therapy and endoscopic evaluation should follow. Urgent risk stratification, prompt hemodynamic stabilization, and endoscopic evaluation and identification of the bleeding source guide further management.

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EPIDEMIOLOGY

Gastrointestinal bleeding can be divided into upper and lower gastrointestinal bleeds with upper gastrointestinal bleeding (UGIB) defined as bleeding from a source proximal to the ligament of Treitz.[1] The annual rate of hospitalization and mortality for UGIB from 1992 to 1999 in the United States ranged from 172 per 100,000 to 149 per 100,000, and 10.9 per 100,000 to 7.8 per 100,000, respectively.[2] In general, the incidence of UGIB has steadily declined; however, the mortality remains stable. For example, from 1993 to 2000 the incidence of UGIBs declined by 23%. This decline is largely attributed to the treatment of *Helicobacter pylori* infection and use of acid-suppressive therapy for peptic ulcer disease (PUD).[3,4] Recent trends show that increased anticoagulation usage has not necessarily affected the incidence of NVUGB; however, the severity of bleeding episodes has worsened.[5] The incidence of NVUGB by diagnosis is documented in **Table 1**.[6]

PATIENT EVALUATION OVERVIEW

Approach to the Upper Gastrointestinal Bleed

A thorough history is vital in determining the cause, acuity, and volume loss following a UGIB. History should begin with an inquiry into the site, time frame, frequency, and intensity of UGIB. It is relevant to distinguish between UGIBs described by hematemesis, coffee-ground emesis, and melena caused by delayed transit of blood compared with lower gastrointestinal bleeding. Relevant past medical history, such as liver disease, PUD, inflammatory bowel disease, Peutz-Jeghers syndrome, and malignancy, have a propensity for gastrointestinal bleeds. Pertinent surgical history includes gastrectomy and abdominal aortic aneurysm repair. Medications should be reviewed for the use of nonsteroidal antiinflammatory drugs (NSAIDs), aspirin, anticoagulants, and antiplatelet agents. In addition, a family history of coagulation disorders may suggest underlying coagulation deficiencies, or a history of recurrent bleeding may suggest hereditary hemorrhagic telangiectasia. A retrospective study identified several clinical variables predictive of UGIB. **Table 2** details pertinent variables that increased the likelihood of UGIB. A Blatchford score of 0 (described later) decreases the likelihood that a UGIB requires intervention.[7]

Anemia and hypovolemia often occur concomitantly. Physicians should recognize signs of hypovolemia, including tachycardia, orthostatic hypotension, and an increased blood urea nitrogen/creatinine ratio. On examination, the color tint of the

Table 1
Incidence of nonvariceal UGIB

Diagnosis	Incidence (%)
Peptic ulcer	20–50
Mallory-Weiss tear	15–20
Erosive gastritis/duodenitis	10–15
Esophagitis/esophageal ulcer	5–10
Malignancy	1–2
Angiodysplasia/vascular malformations	5
Other	5

From Ferguson CB, Mitchell RM. Non-variceal upper gastrointestinal bleeding. Ulster Med J 2006;75(1):32–9.

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