GI BLEED MANAGEMENT IN PATIENT WITH KNOWN OR SUSPECTED CIRRHOSIS

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PURPOSE: To delineate clinical guidelines for the management with known or suspected cirrhosis who are experiencing GI bleeding. This protocol is meant to provide a general guideline to care, the clinical circumstances and treatment of each patient will be evaluated on a case by case basis.

Note: Please also review separate protocols for Esophageal and Gastric Varices Management.

POLICY:

I. Patients with active GI bleeding and cirrhosis should be managed in the ICU

II. NG tube should be placed to intermittent suction if active hematemesis (there is minimal danger of disrupting varices or banded varices); NG tube should be discontinued if no evidence of active bleeding. Do not use continuous suction.
   
   A. There is no risk of worsening or causing bleeding in those with esophageal varices both pre- and post-banding.

III. Hepatologist/Gastroenterologist to consult and provide urgent upper endoscopy (<12 hours mandatory for active bleeding)

IV. The following treatment of upper GI bleeding is recommended:
   
   A. Octreotide 50 mcg IV bolus, 50 mcg/hr infusion for 3-5 days after bleeding diagnosis. (Note: Octreotide to be continued after successful hemostasis such as banding, sclerotherapy, or glue. Octreotide can be discontinued after EGD if non-portal HTN bleeding identified)
   
   B. Intubate for airway protection if ongoing active hematemesis and/or patient is confused or unable to protect airway.
   
   C. IV antibiotic prophylaxis (quinolone, zosyn or cephalosporin recommended) should be initiated and transitioned to oral medication once tolerating PO. A total duration of 7 days should be utilized.
      
      i. Quinolone-Ciprofloxacin 500mg PO BID or Norfloxacin 400mg BID
      ii. Cephalosporin-Ceftriaxone 1 gram daily
      iii. Zosyn 3.375 grams IV q6
       
      Antibiotics have been shown to prevent infections (SBP and pneumonia) as well as rebleeding
   
   D. PPI drip should be utilized initially until cause of bleeding identified and treated during endoscopy. Following endoscopy, if no evidence for high risk ulcer bleeding, then IV PPI should be given Q12hrs until able to tolerate PO. Then oral PPI QD or BID.
   
   E. If massive bleeding: consider placement of Minnesota Tube; patient to be intubated if using Minnesota tube and maximum duration of use is 24 hours; place “code blue” gastric lavage tube at the bedside
   
   F. Consider TIPS shunt if MELD <23 and t bili <3
   
   G. Restrictive transfusion policy
      
      i. Maintain target hemoglobin between 7 and 8 gm/dL
ii. Generally avoid transfusions unless Hgb < 7.0 gm/dL and evidence of active bleeding
   1. Consider each unit of PRBCs individually (i.e. do not always transfuse 2 units)
iii. More liberal transfusion regimen recommended in setting of concomitant CAD or other ischemic conditions
H. Thromboelastography (TEG) should be used to guide transfusion of FFP, cryoprecipitate and platelets in cirrhotics with GI bleeding both pre and post-procedure
   i. See TEG algorithm for those with chronic liver disease
I. Use of DDAVP to aid in platelet function for those with uremia

References: