Haematemesis

Evaluation and initial risk assessment
• Effects of Haemorrhage – assessment of amount of melaena/haematemesis. B.P, Pulse rate, skin perfusion. Syncope Haemoglobin, blood urea,
• Other significant disease- Cardiovascular, respiratory, renal, hepatic.
• Other symptoms Chest pain, dyspnoea, Jaundice
Patients with
  o Continuing bleeding
  o Shock- Systolic B.P.<100; Pulse>100
  o Significant co-morbid disease
  o Bleeding varices
  o Low admission Haemoglobin
  o High urea
  o Anticoagulant therapy
Are at significant risk of re-bleeding and death

Resuscitation
Venous access
• 2 Large bore cannulas to allow fast blood transfusion and/or simultaneous blood and fluid infusion
• Patients who are shocked, actively bleeding or bleeding form varices should have a central venous catheter

Transfusion
• Initial resuscitation should be with plasma expander and saline.
• Patients with HB <10 G, who are actively bleeding or bleeding from varices should have transfusion with packed cells
• Consider fresh frozen plasma or platelet transfusion in patients with prothrombin time >20 secs, or platelet count <50,000.

Monitoring
• B.P. and pulse 15mintes initially
• Urinary catheter for hourly urine volumes
• Central venous pressure when appropriate – fluid assessment; early indication of bleeding

Investigations
• Immediate – Hb, U&E, Prothrombin time, ECG, CXR, blood group
• Further – LFT, endoscopy

Endoscopy
Endoscopy should be done in all patients with a definite bleed within 24 hours. In patients who have had severe bleeds endoscopy should be within 12 hours but only after adequate resuscitation. Endoscopy allows precise diagnosis of the cause of bleeding, more accurate risk assessment and in many circumstances therapy of the bleeding source
Haematemesis (continued)

Post endoscopy risk assessment
Combination of the endoscopy findings and clinical risk features allows a validated risk calculation - the Rockall score\(^1,2\).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Score</th>
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<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Age</td>
<td>&lt;60</td>
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<tr>
<td>Shock</td>
<td>None</td>
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<tr>
<td>Co-Morbidity</td>
<td>None</td>
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<tr>
<td>Diagnosis</td>
<td>M.W. tear, No lesion and no S.R.H.</td>
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<tr>
<td>S.R.H.</td>
<td>None or Dark spot</td>
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S.R.H. = Stigmata of Recent Haemorrhage

Maximum score before endoscopy =7   Maximum Score after endoscopy =11
Scores above 4 associated with progressive rise in rebleeding and mortality

Score 4 ~10% mortality: 8~50%mortality   2 or below- consider early discharge

Surgical referral
Patients at high risk of further haemorrhage and death should be discussed with and managed jointly with the surgical team