

Upper Gastrointestinal Bleeding – Time to redefine our labels?

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Dear Editor,

Upper gastrointestinal (GI) bleeding, defined as bleeding which occurs proximal to the ligament of Trietz, is a common presentation to Emergency Departments (ED) nationally. Despite published guidance on the best management of these patients, significant variability exists between hospitals in their local protocols.¹

Current risk stratification in the Emergency Department largely focusses on identifying patients who either need admission for investigation and management and those who can be safely discharged from the Emergency Department, pending outpatient follow up. The Glasgow Blatchford Score, first developed in 2000, allows such a risk assessment to be carried out using clinical, haematological, and biochemical parameters which are readily available to Emergency Medicine (EM) clinicians. Patients with a score of 1 or less are identified as being safe for discharge with outpatient follow up, while a score greater than 1 requires inpatient assessment.² The Blatchford score has been validated many times and it has been shown that with a cut-off score of ≤ 1 , it outperforms other risk stratification tools at predicting 30 day mortality, need for transfusion, surgery or need for endoscopic treatment of bleeding.³

While this assists decision making regarding admission or discharge from the ED, risk stratification among patients who require admission is more *ad hoc*. We observe that patients are labelled as 'stable' or 'unstable' based upon the overall impression of the treating clinician. In our experience, this poses a major problem. There appears to be no clear consensus on the definition of 'stable' or 'unstable'. However, we allow this label to dictate the course of treatment for our patients with upper GI bleeding who require admission.

To examine this, we recently polled a sample of Medical and EM registrars to determine their impressions of the terms 'stable' and 'unstable'. Each group were asked to define a 'stable' upper GI bleed and subsequently asked to determine if a patient was 'stable' or 'unstable' based upon 3 clinical vignettes. The results demonstrated significant variability both among and between specialties, with Emergency Medicine registrars tending to favour labelling patients as 'unstable' when compared to Medical registrars. The same 3 vignettes were posed to a recent gathering of surgical teams in the same hospital, who again demonstrated the same inconsistent labelling.

In many institutions, patients with upper GI bleeding labelled as ‘unstable’ are typically admitted under the surgical team on call while ‘stable’ bleeds are admitted medically. While data is not readily available on differences in time to endoscopy or likelihood of blood transfusion, deterioration or death, anecdotally, different teams will have variable access to endoscopic suites and alter their management plan accordingly. Confounding this further, recent evidence suggests that endoscopy carried out too early may be harmful⁴ and that there is no ‘weekend effect’ for patients admitted out of hours with upper GI bleeding.⁵

We propose that the labels of ‘stable’ or ‘unstable’ could be replaced with a more objective assessment of our patients to best dictate the course of treatment following a decision to admit by an Emergency Medicine clinician, rather than focus on the choice of admitting team.

Declarations of Conflicts of Interest:

None declared.

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