ICR-UGIB-003

Gastrointestinal emergencies

Updated 20 Jun 2026

CRITICAL CARE ORDER SET

Upper GI bleeding

ICU management of suspected or confirmed adult upper GI bleeding — resuscitate first, protect the airway, give a PPI, and cover for varices when cirrhosis is suspected. Restrictive transfusion, early endoscopy, and a clear rebleeding plan drive outcomes. Adapt every dose to your institutional protocol and the patient in front of you.

PATIENT	MRN	WEIGHT (KG)	DATE / TIME
ALLERGIES	**ATTENDING**	**ORDERING CLINICIAN**	**CODE STATUS**

01 Admission & monitoring

LOCATION

- [ ] Admit / transfer to **ICU**

MONITORING

- [ ] Continuous cardiac monitoring
- [ ] Continuous pulse oximetry
- [ ] NIBP `q5–15 min` — arterial line if on vasopressors or labile BP
- [ ] Strict intake & output; Foley catheter if shock / vasopressors, oliguria, or need for close fluid balance

02 Airway & breathing

- [ ] Elevate head of bed `30–45°`
- [ ] Yankauer suction at bedside

INTUBATE Consider **early intubation** for ongoing large-volume hematemesis, inability to protect the airway (GCS < 8–10), severe agitation / encephalopathy (esp. cirrhosis / varices), or anticipated urgent endoscopy in a high-risk airway.

IF INTUBATING

- [ ] RSI with aspiration precautions
- [ ] Use ETT ≥ `7.5 mm` when possible (facilitates endoscopy)

03 IV access & resuscitation

- [ ] Two large-bore peripheral IVs (`16–18 G`) and/or central venous catheter

FLUIDS

- [ ] Balanced crystalloid bolus `500–1000 mL`; repeat as needed, guided by BP, MAP, lactate, and exam

VASOPRESSORS

- [ ] Start `norepinephrine` if SBP below target despite resuscitation

TARGET SBP goal **80-90 mm Hg** — individualize in chronic hypertension or CAD.

04 Laboratory & diagnostics

STAT NOW, THEN PER PROTOCOL

- [ ] CBC
- [ ] Coagulation — PT / INR, aPTT
- [ ] CMP
- [ ] Type & screen / crossmatch (2–4 units PRBC)

- [ ] Lactate
- [ ] Venous or arterial blood gas (if shock / respiratory failure)
- [ ] Troponin & ECG (if middle-aged or older, CAD, or shock)
- [ ] Pregnancy test (if applicable)

FOLLOW-UP LABS

- [ ] CBC `q6 h` until stable, then `q12–24 h`
- [ ] Repeat CMP / coagulation daily or as indicated

05 Transfusion & coagulation

> **STRATEGY** Use a **restrictive** transfusion threshold — over-transfusion worsens portal pressure and rebleeding. Target INR `< 1.5–2.0` but do not delay urgent endoscopy.

PACKED RBCS

- [ ] Transfuse if `Hgb ≤ 7 g/dL` (most patients)
- [ ] Consider `7–8 g/dL` threshold in CAD, active ischemia, persistent tachycardia / hypotension, or ongoing bleeding

PLATELETS

- [ ] Transfuse to `platelets > 50,000/µL` with active bleeding or before high-risk procedures

REVERSE ANTICOAGULATION

- [ ] **Warfarin** — IV vitamin K `5–10 mg`; 4-factor PCC (or FFP) for life-threatening bleed / emergent procedure
- [ ] **DOACs** — hold; consider specific reversal for life-threatening bleeding (idarucizumab; andexanet alfa or 4F-PCC)
- [ ] **Heparin** — stop; protamine for significant bleeding on IV UFH or recent SC dose

06 Empiric medications

PROTON PUMP INHIBITOR — ALL UGIB UNLESS CLEAR ALTERNATIVE

- [ ] `Pantoprazole 80 mg IV` bolus, then `8 mg/h` infusion

OR

- [ ] **`Pantoprazole 40 mg IV`** q12 h (per local policy)

SUSPECTED / KNOWN VARICEAL BLEEDING

- [ ] **`Octreotide 50 µg IV`** bolus, then **`50 µg/h`** infusion — continue 2–5 days if confirmed
- [ ] **`Ceftriaxone 1 g IV`** q24 h for up to 7 days (alternative per antibiogram if severe β-lactam allergy)

ADJUNCTS

- [ ] Consider **`erythromycin 250 mg IV`** 30–90 min pre-EGD (per GI preference)
- [ ] Hold NSAIDs; hold / modify antiplatelet / anticoagulant therapy. Primary-prevention aspirin: generally hold. Recent coronary stent / high CV risk: consult cardiology.

07 Consults & procedures

TIMING Goal EGD **< 24 h**; **< 12 h** if unstable or suspected varices.

- [ ] **Gastroenterology** — urgent
- [ ] Anesthesia for EGD (if intubation or high-risk airway)
- [ ] Hepatology for suspected variceal bleed / decompensated cirrhosis
- [ ] Interventional radiology and surgery on standby for refractory / recurrent bleeding

LINES / ACCESS

- [ ] Arterial line for shock or if vasoactive agents required
- [ ] Central line as needed for pressors or difficult access

08 Nutrition & activity

- [ ] NPO (including oral medications) except essential IV meds, until post-EGD plan
- [ ] Advance diet post-EGD per GI: clear liquids → advance as tolerated if low-risk lesion and stable

09 Rebleeding surveillance & escalation

MONITOR FOR REBLEEDING

- [ ] Hematemesis, new melena, or hematochezia
- [ ] HR > 100, SBP < 90, or MAP < 65 after initial stabilization
- [ ] Hgb drop ≥ `2 g/dL in 24 h` not explained by hemodilution
- [ ] Increased transfusion requirement (`> 4 units / 24 h`)

ESCALATE If rebleeding is suspected: notify GI and ICU immediately, resuscitate, and prepare for repeat EGD ± IR or surgery. For uncontrolled variceal hemorrhage, consider **balloon tamponade** as a bridge to TIPS / IR / surgery.

- [ ] Notify GI and ICU team immediately
- [ ] Resuscitate — fluids, blood, pressors as needed
- [ ] Prepare for repeat EGD ± IR or surgery

10 After endoscopy — checklist

- [ ] Document endoscopic diagnosis and risk stigmata
- [ ] Adjust PPI regimen — high-dose 72 h vs standard

IF VARICEAL BLEED

- [ ] Continue octreotide 2–5 days
- [ ] Continue antibiotics up to 7 days
- [ ] Plan nonselective beta-blocker once hemodynamically stable
- [ ] Schedule repeat banding per hepatology

- [ ] Order *H. pylori* testing if ulcer disease
- [ ] Review and adjust long-term antiplatelet / anticoagulant therapy with cardiology, hematology, and GI

EDUCATIONAL USE ONLY

Not a substitute for clinical judgement. Verify doses, allergies, renal function, and contraindications. Adapt all agents and thresholds to your institutional protocols, formulary, and the individual patient.

Spreading knowledge
Improving outcomes