Introduction

Non-variceal GI bleeding is an important cause of acute hospital admission. In many cases patients are simply observed and then discharged if haemodynamically stable. 1

Various risk stratification tools are used to initially assess patients, including the clinically-based Glasgow-Blatchford Bleeding Score (GBS – figure 1). Evidence suggests that low-risk patients may be safely managed as outpatients. 1,4

A tertiary centre introduced an ambulatory care protocol incorporating risk-stratification using GBS, with subsequent senior review, dedicated endoscopy slots and specialist follow-up as required (figure 2). This retrospective audit reviews ambulated cases since the protocol's introduction.

Methods

All patients with suspected non-variceal bleeds presenting to Primary Assessment Area (PAA) between August 2011 and April 2012 were eligible, including those referred directly from GPs or initially assessed in the Emergency Department (ED). Details were collected from the Ambulatory Care admissions book, and subsequently from medical notes and electronic records.

Results

30 patients were managed in ambulatory care with 28 having GBS ≤1. One patient (GBS 2) was ambulated after ED consultant review. A further patient (GBS 9) was ambulated inappropriately from PAA, although without harm. Figure 3 shows outcomes of the 27 patients (90%) who returned for assessment. The 3 non-attenders were all males under the age of 25.

Of note, there were no haemodynamically significant events when GBS ≤2.

In total, 22 patients underwent endoscopy, 19 on the same day of their return visit. No patients with GBS ≤2 required endoscopic therapy or transfusion. 9 patients had normal endoscopies, with a further 7 showing inflammation and 5 evidence of Mallory Weiss tears or ulceration. The patient with GBS 9 required endoscopic adrenaline for an oozing duodenal ulcer. 6 patients were referred for outpatient appointments.

Conclusions

This audit suggests that ambulatory management using GBS is safe for low-risk patients. Although what constitutes a low-risk GBS remains uncertain.

All patients undergoing ambulatory care were managed without harm, although one case was managed inappropriately and subsequently reviewed internally. A majority (19/27) of patients underwent endoscopy on the day of their return visit, despite low-risk scores and no signs of haemodynamic instability. Most (15/19) were then discharged from secondary care. Given that no patients with GBS ≤2 required endoscopic intervention, a higher threshold for endoscopy may be warranted.

Some minor amendments to the protocol were suggested, with good practice regarding clear documentation emphasised.

References