Oesophageal variceal bleeding

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Definition

Oesophageal variceal bleeding refers to bleeding from dilated sub-mucosal veins (varices) of the distal part of the oesophagus, resulting from portal hypertension. This is the most common cause of GI bleeding in patients with cirrhosis.

Bleeding is often massive and mortality is as high as 50% (1).

Clinical features

- Symptoms: haematemesis, melaena and/or haematochezia, dizziness or light-headedness, syncope

- Signs: hypovolaemic shock (e.g. tachycardia, hypotension), altered mental status, anaemia (1)

Differential diagnosis of UGIB

- Oesophagitis, gastritis, or duodenitis
- Peptic ulcer disease
- Mallory-Weiss tear
- Malignancy
- Other (1)

Assessment

- Check pulse and BP (including postural drop)
- Assess for signs of chronic liver disease
- Check FBC, coagulation screen, U&Es, LFTs
- Crossmatch 6 units of blood
- Risk assessment:
    - The Blatchford score at first assessment, and
    - The full Rockall score after endoscopy (2,3)

Management

The following management should be carried out in patients with suspected variceal bleeding on the basis of having evidence of chronic liver disease and evidence of a significant GI bleed prior to diagnosis being confirmed.

- If there is evidence of shock – insert urinary catheter and consider CVP line insertion
- Consider HDU admission
- Correct any clotting or platelet abnormality (discuss with haematology)
- Resuscitate with blood or colloid aiming to keep Hb >70, pulse <100bpm, systolic BP >90-100mmHg, CVP of 8-10cm and urine output >30ml/hour.
- Start appropriate drug therapy
- If ascites is present, perform ascitic tap
- Seek help from seniors
    - If stable, should be listed for urgent endoscopy
    - If unstable, liaise with on-call endoscopist
    - Anaesthetic support and transfer to ITU may be necessary

Drug therapy

Unless contraindicated (cardiovascular disease) start:

- Terlipressin 2mg by IV bolus followed by 1-2mg every 4-6 hours until bleeding controlled, for up to 48 hours
- Co-amoxiclav 1.2g IV every 8 hours (or clarithromycin 500mg IV every 12 hours if penicillin allergy) (2)

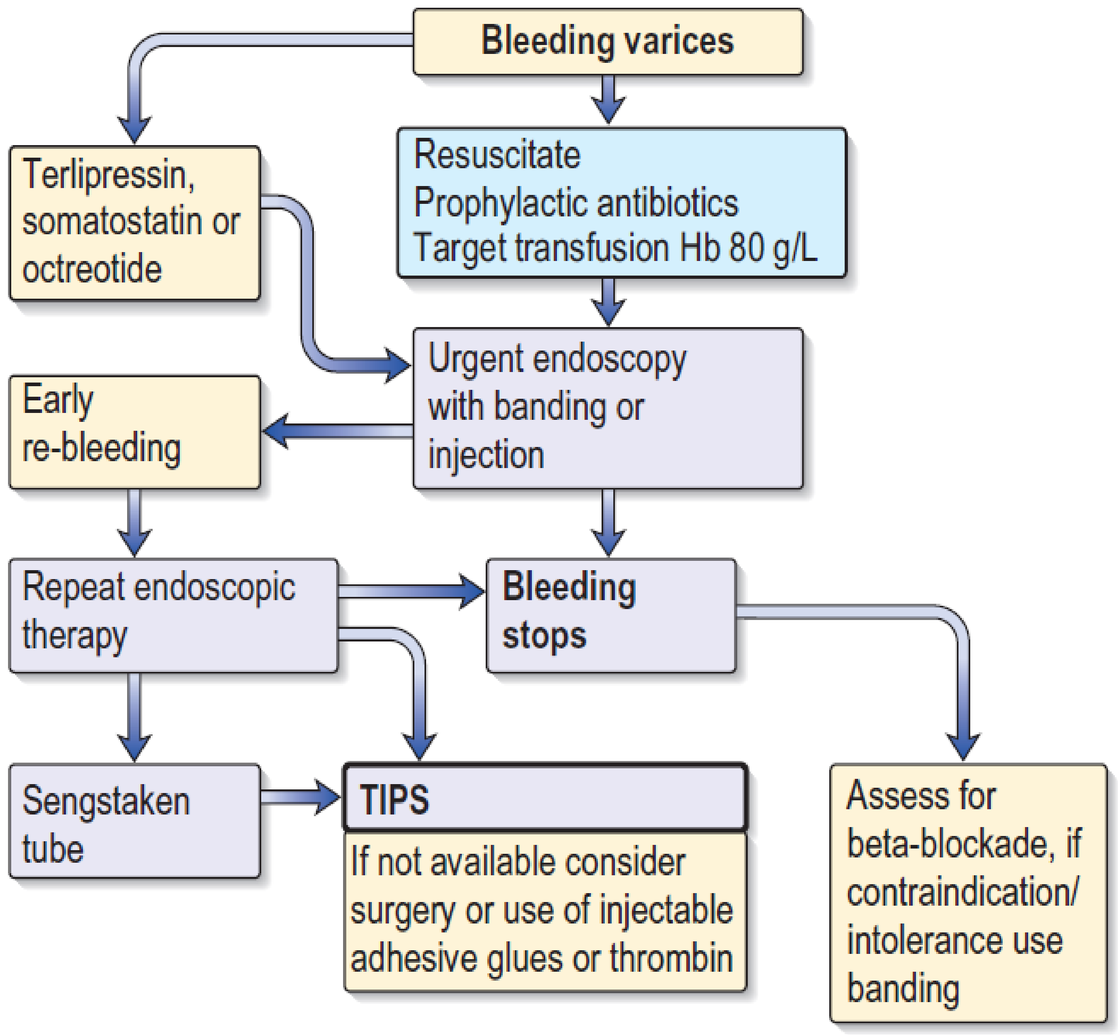
Endoscopy

- Offer endoscopy to unstable patients immediately after resuscitation
- Use band ligation in patients with upper GI bleeding from oesophageal varices
- Consider transjugular intrahepatic portosystemic shunts (TIPS) if bleeding not controlled by band ligation (3)

Prevention of rebleeding

- Enter into variceal eradication programme – discuss with gastroenterologist
- Start propranolol 50mg PO twice daily if no contraindication and titrate up to 160mg once daily sustained release preparation if tolerated
- Give advice on alcohol intake and refer to addiction services if appropriate (2)

Summary (4)



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