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Upper Gastrointestinal Bleeding (UGIB) Inpatient Referrals
An Audit On Identifying Gaps For Optimal Gastroscopy Delivery

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INTRODUCTION

- Acute upper GI bleeding (UGIB) is a potentially life-threatening abdominal emergency. BSG and ESGE advocate endoscopy to be performed within 24 hours as early intervention is associated with better prognosis with reduced morbidity and mortality.
- Patient risk stratification is crucial and includes pre-assessment scoring systems incorporating parameters predicting haemodynamic stability.

AIMS

- The primary study aims were to define the volume of endoscopy referrals for upper GI bleeding and identify factors associated with time to endoscopy in patients with UGIB.
- A secondary aim was to assess the quality of referral information by evaluating the proportion of patients with a calculated Glasgow Blatchford score (GBS) and the proportion of referrals formally discussed by the referring team with the endoscopy service.

METHODS

- Prospective study was conducted over an 8-week period from February to April 2021.
- All inpatient UGIB referrals were triaged by a Consultant Gastroenterologist in the endoscopy unit. A questionnaire was completed the Consultant Gastroenterologist and triaging endoscopy nurse at the time of receipt of referral.
- The electronic patient record and theatre records were interrogated to collect clinical and endoscopic data..

RESULTS

Number of cases (n)	63
Endoscopy ICU Theatre	54 (86%) 4 (6%) 5 (8%)
>24 Hours Due to Bank Holiday/Weekend	16 (25%) 10
Cases discussed with Triaging Endoscopist	52%

RESULTS

- 75% (n=47) upper GI endoscopies were performed within 24 hours of referral, 25% (n=16) upper GI endoscopies were performed after an interval of >24hrs. Median time from referral to endoscopy was 7 hrs (range, 1.5 - 48).
- Reasons identified for an upper GI endoscopy being performed at an interval > 24 hours included: weekend / bank holiday (n=10), requirement for blood product resuscitation (n=1), infection status (n=2), patient refusal (n=1) and unclear reason (n=2).
- GBS was documented in only 20% (n= 12) of referrals.
- Median GBS was 12 (range, 12-14) for cohort undergoing upper GI endoscopy in operating theatre setting compared to 8.5 (range, 1-16) in endoscopy unit cohort (p value <0.00001)

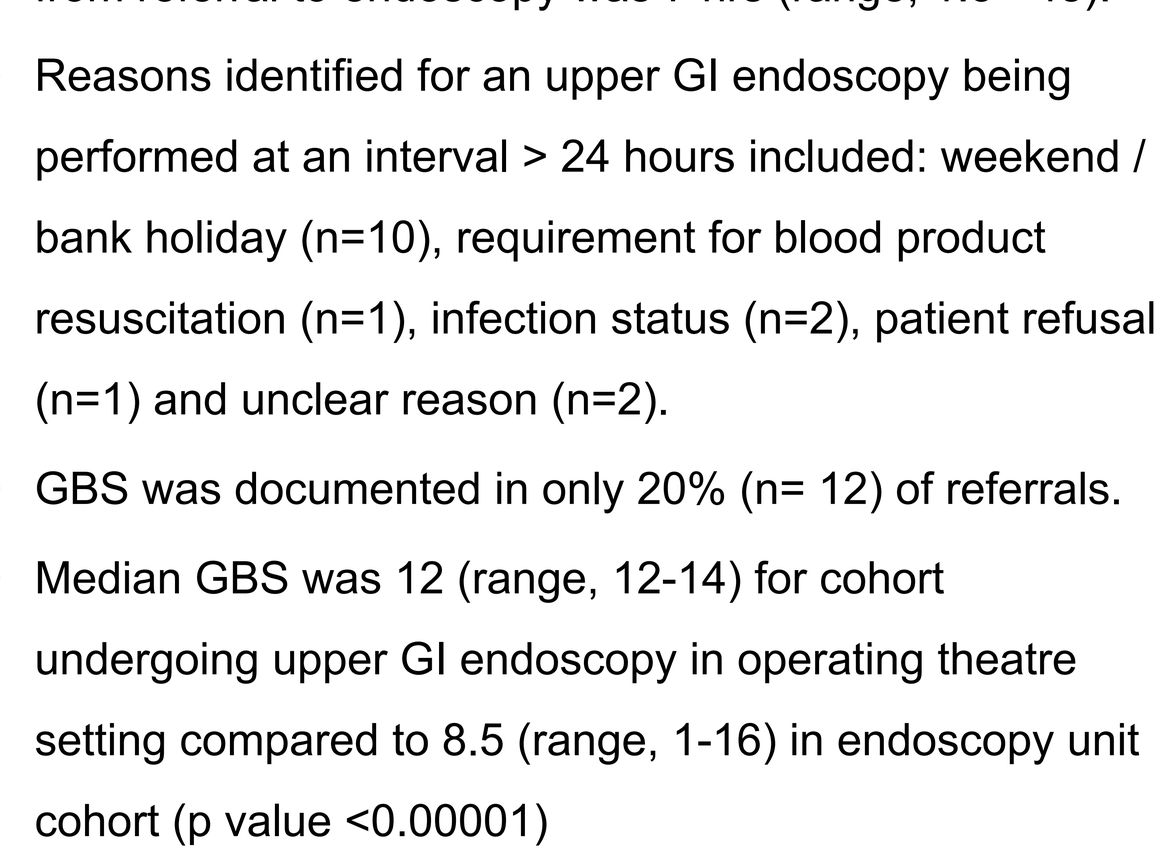

Fig 1: Scatter Plot of Cases: Delays vs GBS

CONCLUSIONS

- In a large academic teaching centre, referral for upper GI endoscopy with an indication of UGIB is a common. The vast majority of endoscopy, performed to asses UGIB, is performed in the endoscopy unit with a minority performed in ICU and operating theatre settings.
- Patients requiring endoscopy in the ICU or theatre setting have more severe UGIB as assessed by GBS.
- Education and implementation of an UGIB care pathway are likely to improve endoscopy triage, pre-procedure care and timely endoscopy access in patients with UGIB.