

Upper GI & Ulcer Bleeding

Risk stratification, pre-endoscopic care, endoscopic hemostasis, and post-hemostasis management of ulcer bleeding.

GRADE Strong Rec Conditional Rec

1 Risk Stratification & Transfusion

2 Very-low-risk patients (e.g., Glasgow-Blatchford score 0–1) can be **discharged** with outpatient follow-up rather than admitted.

2 Restrictive RBC transfusion policy – threshold hemoglobin **7 g/dL**.

2 Pre-Endoscopic Medical Therapy

2 Erythromycin infusion before endoscopy.

NR No recommendation for or against pre-endoscopic PPI therapy.

3 Timing & Indications for Endoscopy

2 Endoscopy **within 24 hours** of presentation for admitted/observed patients.

1 Endoscopic therapy for ulcers with **active spurting, active oozing, or nonbleeding visible vessels**.

NR No recommendation for or against therapy in ulcers with **adherent clot** resistant to vigorous irrigation.

4 Choice of Hemostatic Modality

STATEMENT	GRADE
Bipolar electrocoagulation, heater probe, or absolute ethanol injection for bleeding ulcers	1·Strong
Clips, argon plasma coagulation, or soft monopolar electrocoagulation as options	2·Conditional
Epinephrine injection not used alone – must combine with another hemostatic modality	1·Strong
Hemostatic powder spray TC-325 for actively bleeding ulcers	2·Conditional
Over-the-scope clips for recurrent bleeding after previous successful hemostasis	2·Conditional

5 Post-Hemostasis Antisecretory Therapy

1 High-dose PPI (continuous or intermittent) for **3 days** after successful endoscopic hemostasis.

2 High-risk patients: continue **twice-daily PPI** until **2 weeks** after index endoscopy following inpatient high-dose therapy.

6 Recurrent & Refractory Bleeding

2 Repeat endoscopy + endoscopic therapy for recurrent bleeding – preferred over surgery or transcatheter arterial embolization.

2 Transcatheter arterial embolization next step after **failed endoscopic therapy**.