key points

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Upper GI bleeding is a common medical emergency with an incidence in the UK of 103 cases per 100,000 adults per year and is much more common in the elderly. The most common presenting signs are haematemesis (bright red or 'coffee ground') and melaena. About 30% of patients with bleeding ulcers present with haematemesis, 20% with melaena, and 50% with both. Up to 5% of patients with bleeding ulcers have haematochezia and this indicates heavy bleeding into the upper GI tract. An upper GI bleeding source should be considered when haematochezia presents with signs and symptoms of haemodynamic compromise.

Peptic ulcer disease, both gastric and duodenal, accounts for the majority of admissions for upper GI bleeding. The main risk factors for developing peptic ulcers are a history of NSAID use or the presence of *H. pylori* infection. Bleeding from oesophageal varices usually results in large volumes of bright red haematemesis. Other causes of bleeding include mucosal (Mallory-Weiss) tear of the gastro-oesophageal junction secondary to vomiting, and multiple types of vascular abnormalities.

Clinical risk factors for mortality in upper GI bleeding are age, comorbidity, tachycardia and a low systolic blood pressure. Given the high mortality rate associated with upper GI bleeding nearly all patients with symptoms described above should be referred to secondary care for emergency admission and endoscopic assessment. This should also be the default position in borderline cases.

Early endoscopy in upper GI bleeding: allows early diagnosis; provides the opportunity for endoscopic haemostasis; enables complete risk stratification of non-variceal bleeding and allows early discharge of patients with low-risk findings. Around a third of patients who present with a bleeding ulcer will develop recurrent bleeding within two years if left untreated after ulcer healing. All patients should be discharged on an oral proton pump inhibitor (PPI) with dosage and duration dependent on the underlying aetiology to decrease the risk of re-bleeding.

Patients with peptic ulcer disease from *H. pylori* who are not using NSAIDs should undergo successful eradication and a further three weeks of PPI therapy. Patients having experienced a bout of upper GI bleeding while on an NSAID should have their treatment discontinued or replaced by an NSAID with PPI cover. Aspirin doubles the risk of upper GI bleeding at daily doses of 75 mg and quadruples it at doses of 300 mg. Patients requiring low-dose aspirin should resume taking aspirin as soon as the cardiovascular risks outweigh the risk of re-bleeding.