



Emergency Medical Abstracts



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Timing of endoscopy for acute upper gastrointestinal bleeding

Lau JYW, Yu Y, Tang RSY, et al. *N Engl J Med.* 2020;382(14):1299-1308.

SUMMARY:

- Acute upper-GI bleed can represent a true emergency, and endoscopy offers both diagnostic (location of type and source of bleed) and therapeutic potential.
- In this randomized trial, the authors focused on patients with acute upper-GI bleed who were at high risk of future bleeding and death.
- The authors assessed bleeding risk with the Glasgow–Blatchford score, a validated tool that generates values from 0 to 23 (with higher scores indicating poorer prognoses) and includes blood pressure, pulse rate and hemoglobin, among other variables.
- The authors chose to include adults with acute GI bleed with a score ≥ 12 , but several previous studies have used a score of 7 as a cut point.
- The study excluded patients who were in shock or could not be stabilized with resuscitation.
- Patients were randomly assigned in a 1:1 ratio to either urgent endoscopy within 6 hours after GI consultation (urgent-endoscopy group) or early endoscopy the next morning and within 24 hours (early-endoscopy group).
- All patients received high-dose IV proton-pump inhibitors (80-mg bolus and 8 mg per hour).
- Of 4,715 screened patients, 598 had a Glasgow–Blatchford score ≥ 12 , 516 of whom were enrolled and randomized (258 per group). The patients were approximately 70 years old, had hemoglobin of 7 g/dL and systolic blood pressure of 110 mm Hg. Ulcers were the source of bleeding in 60% (varicies <10%).
- The mean time from presentation to GI consultation was 7.4 hours in the urgent-endoscopy group and 8.0 hours in the early-endoscopy group, and the mean time from GI consultation to endoscopy was 2.5 hours and 16.8 hours, respectively.
- Of note, emergency endoscopy was performed in 7.8% of the early-endoscopy group because of new-onset signs of bleeding, eg, hypotension, hematemesis, or decreased hemoglobin.
- All-cause 30-day mortality did not significantly differ (8.9% in the urgent group vs 6.6% in the early group).
- Further bleeding was seen in 10.9% of the urgent group vs 7.8% of the early group. The hospital and ICU length of stay was similar, and the blood-transfusion amount and proportion were comparable between groups.

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EDITOR'S COMMENTARY: In this RCT on patients who were sick but had stable upper-GI bleeds largely from peptic ulcer disease, there was no benefit to getting endoscopy within less than 6 hours from the time of GI consult rather than within 24 hours, and the data actually slightly favor waiting within the standard timeframe. These patients all still need an immediate GI consult, so they can get on the board for a scope the next morning. Be vigilant, because even in this stable cohort, 10% of the early group decompensated and crossed over to require urgent therapy. Again, these findings cannot be generalized to unstable patients with active bleeding.