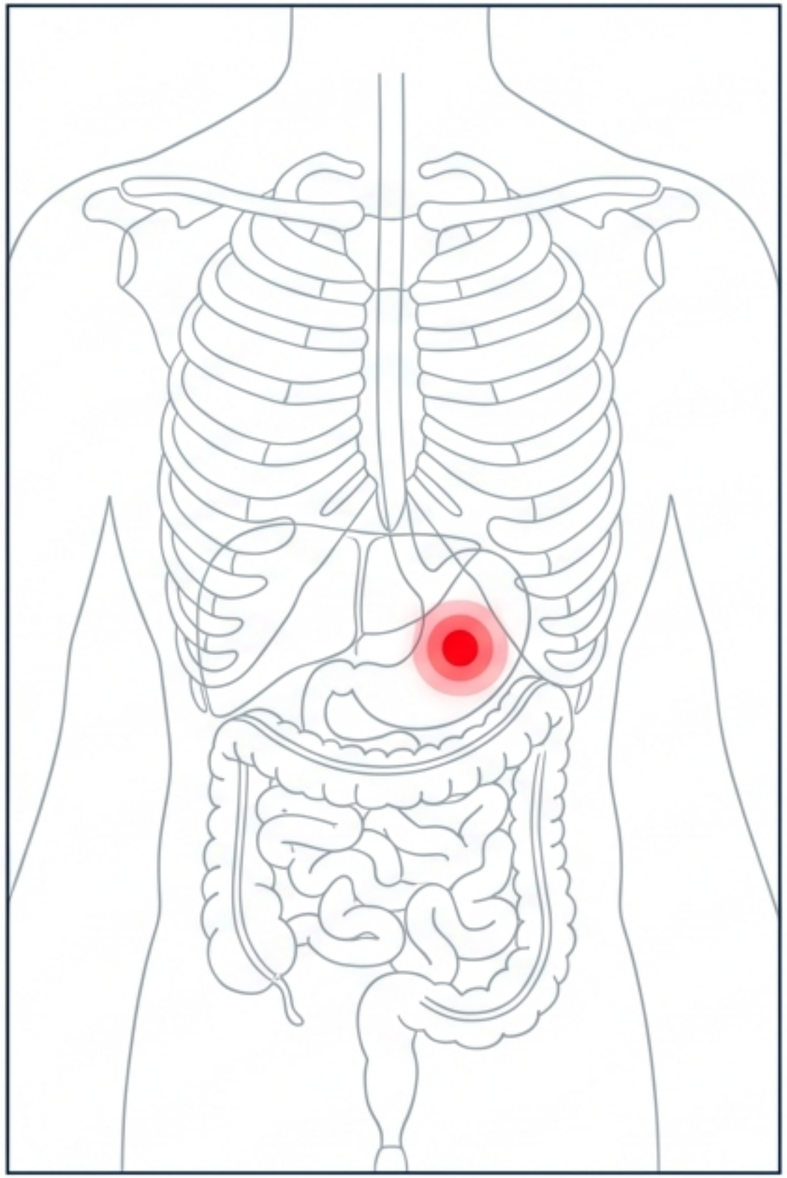
Acute GI Bleeding Triage Interface

Rapid risk stratification, resuscitation protocols, and emergency handoff guidelines for the primary care physician.



Clinical Guidelines: Gastrointestinal // Version: Active Protocol

The Australian burden of acute GI bleeding

Annual Hospital Admissions

15,000

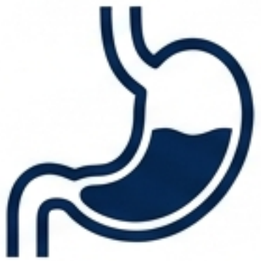
Total Annual Cases

Mortality Split

Upper GI Bleeds
6-10% baseline mortality. Spikes to 20% in ≥80 years.

Lower GI Bleeds
2-4% baseline mortality.

Primary Culprits



Peptic Ulcer Disease (40–50%)

Diverticular Disease (30–40%)

30–40% of all acute admissions are compounded by concurrent anticoagulant or antiplatelet therapy.

Stratifying clinical presentations by immediate risk

Low Risk (Minor Bleeding)

Symptoms
Coffee grounds, trace melaena.

Vitals
Stable, Hb >100.

Action
Arrange urgent outpatient GI review (24-48h).

High Risk (Significant Bleeding)

Symptoms
Recurrent haematemesis, ongoing melaena, mild postural symptoms.

Vitals
HR 90-100, SBP 90-100, Hb 80-100.

Action
Urgent ED transfer (Call 000).

Critical (Life-Threatening)

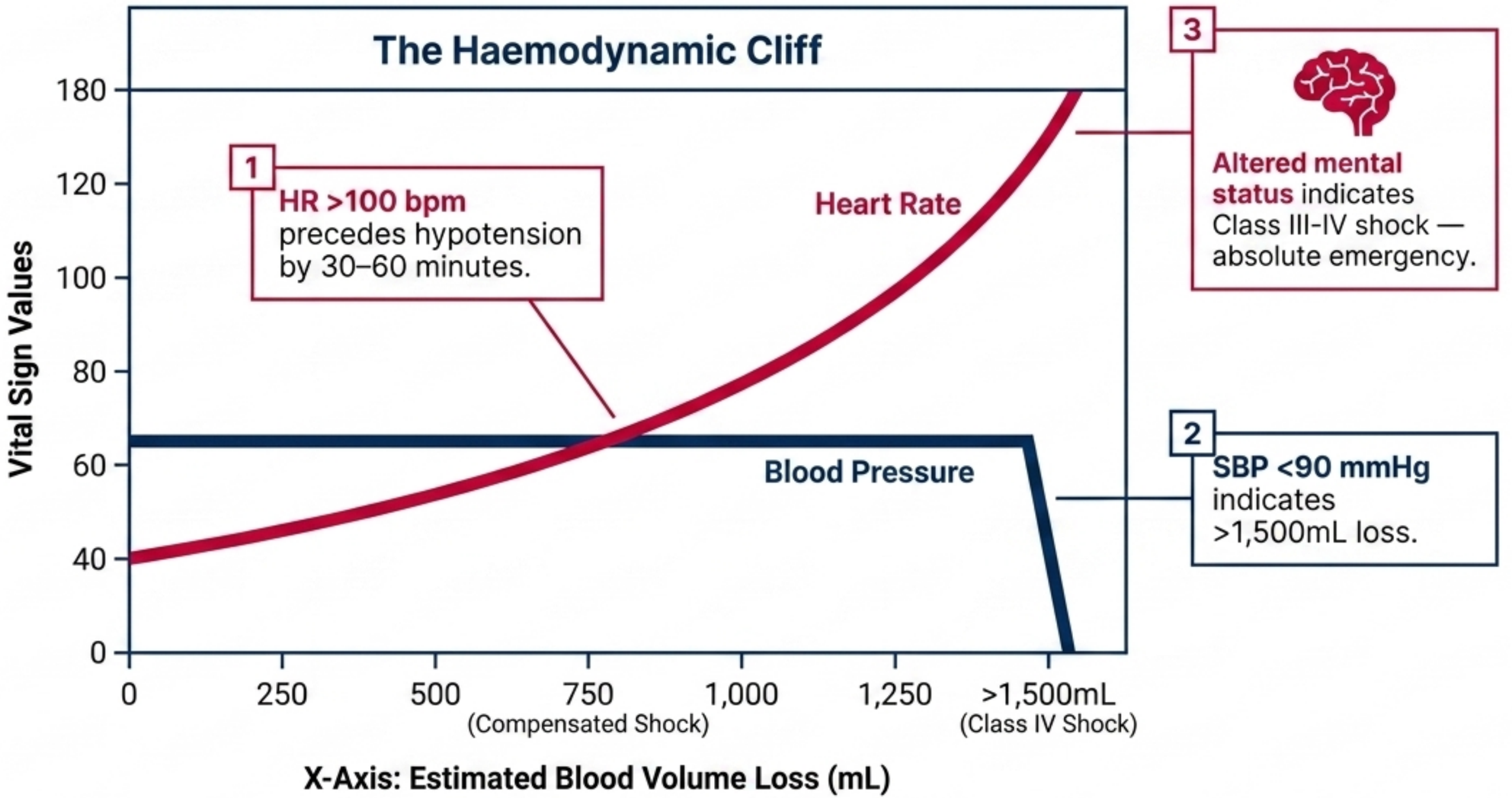
Symptoms
Frank haematemesis with clots, brisk haematochezia, syncope.

Vitals
HR >100, SBP <90.

Action
Emergent transfer (000), immediate clinic resuscitation.

KEY INSIGHT: The absence of visible blood does not exclude significant haemorrhage. Melaena may be entirely occult to the patient.

Tachycardia precedes the haemodynamic cliff



Detecting 15% volume depletion before supine vitals fail

Supine

Standing

Measure after 5 min supine.

Measure again at **1 min and 3 min standing.**

POSITIVE IF:
Systolic drop ≥20 mmHg
OR
Diastolic drop ≥10 mmHg
OR
HR increase ≥20 bpm.

Clinical Takeaway:
A positive orthostatic test implies ≥15% blood volume loss (~750 mL in a 70kg adult).

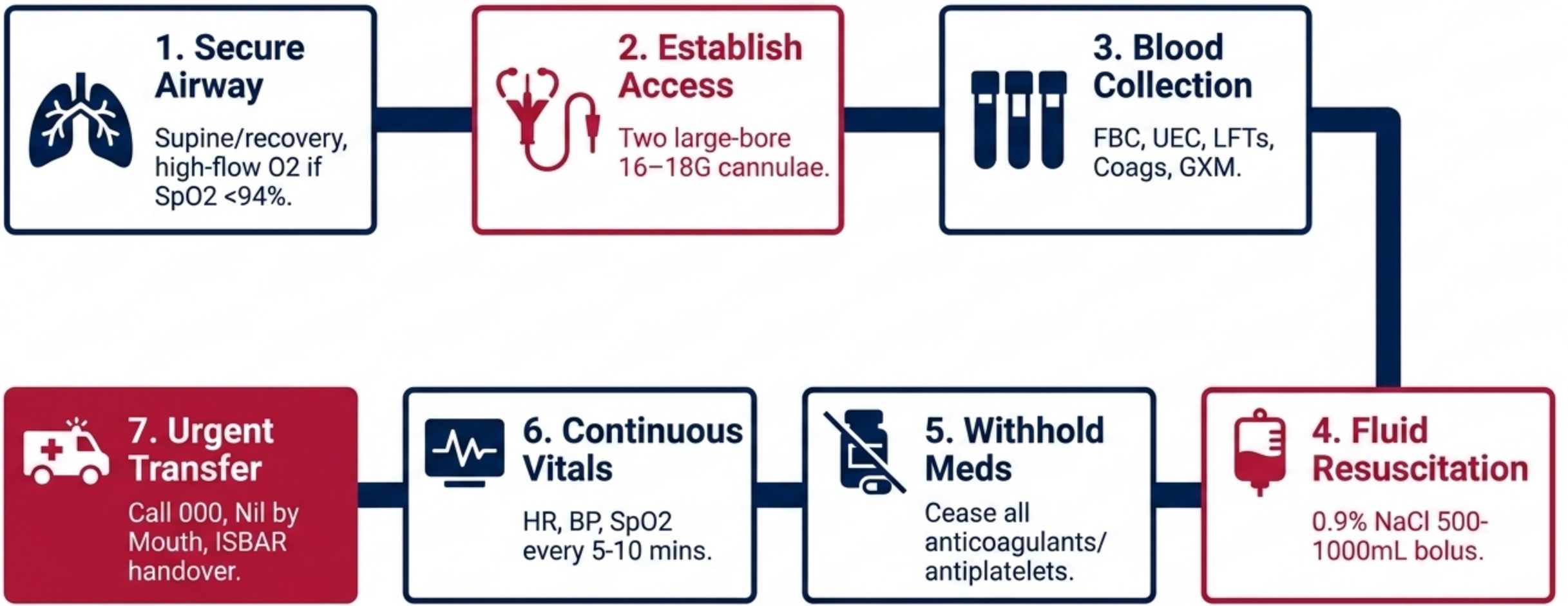
The brisk haematochezia pitfall

Haematochezia (bright red blood per rectum) usually signifies a lower GI bleed. However,

massive, rapid upper GI haemorrhage can overwhelm the gut's digestive capacity, resulting in brisk haematochezia.

PROTOCOL RULE: Brisk Haematochezia + Haemodynamic Instability = Assume Upper GI source until proven otherwise. Requires emergent transfer for dual-endoscopy.

The 7-step primary care immediate action protocol



Calibrating fluid resuscitation based on aetiology

Standard GI Bleed

Administer 0.9% NaCl 500–1,000 mL bolus over 15–30 min. Repeat based on response.

Known/Suspected Cirrhosis

WARNING: Permissive Hypotension. Do not over-resuscitate variceal bleeds. Pushing blood pressure to normotension increases portal pressure and actively worsens variceal haemorrhage.

The anticoagulation and antiplatelet action matrix

Medication Class	Primary Care Action	Definitive Hospital Action
Warfarin	**Cease immediately.** Do not reverse. Check INR.	**Vitamin K** (5-10mg IV) + **Prothrombin Complex Concentrate** (PCC) if INR >4.0.
DOACs (Apixaban, Rivaroxaban, Dabigatran)	**Cease immediately.** Note exact time of last dose.	**Idarucizumab** for dabigatran. **Andexanet alfa** for Factor Xa inhibitors.
Antiplatelets (Aspirin, Clopidogrel, Ticagrelor)	**Cease immediately.** Note recent coronary stents (<12mo).	Cardiology consult for resumption timeline.

RULE: Never administer reversal agents in primary care. Reversal decisions require specialist oversight.

Structuring the critical clinical handoff

Transfer Ticket

[I] Introduction
GP Name, Clinic, Patient Age/Sex.

[S] Situation
Referring for emergency assessment of [haematemesis / melaena].
Patient is [stable / compromised].

[B] Background
CRITICAL DATA: Exact last dose of anticoagulants. Liver disease status. Previous GI bleeds.

[A] Assessment
Vitals trend (Timestamped). Orthostatic results. Estimated volume loss.

[R] Recommendation
Request 2-4 units GXM. ETA of ambulance.

Medication history is the single most critical data point for the receiving team.

Document exact timings.

Time to definitive haemostasis dictates survival

Draw & Send Immediately

- **FBC** (note: Hb may be falsely normal early)
- **UEC** (elevated urea suggests upper GI)
- **Coags**
- **GXM** (2-4 units)
- **Point-of-Care Lactate** (>2 = hypoperfusion)

Do Not Delay Transfer For

- **Upper GI Endoscopy**

- **Colonoscopy**

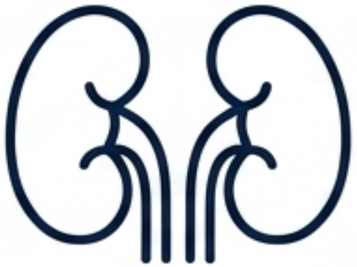
- **CT Angiography**

RULE: The primary care role is to initiate, not complete, the diagnostic workup. If basic bloods cannot be drawn within 15 minutes, abort collection and transfer.

High-risk archetypes require pathway deviations

The Elderly (≥65)

- Mortality spikes to 20% >80yrs.
- May present atypically (falls/confusion).
- Start fluids at **500mL** to avoid **pulmonary oedema**.



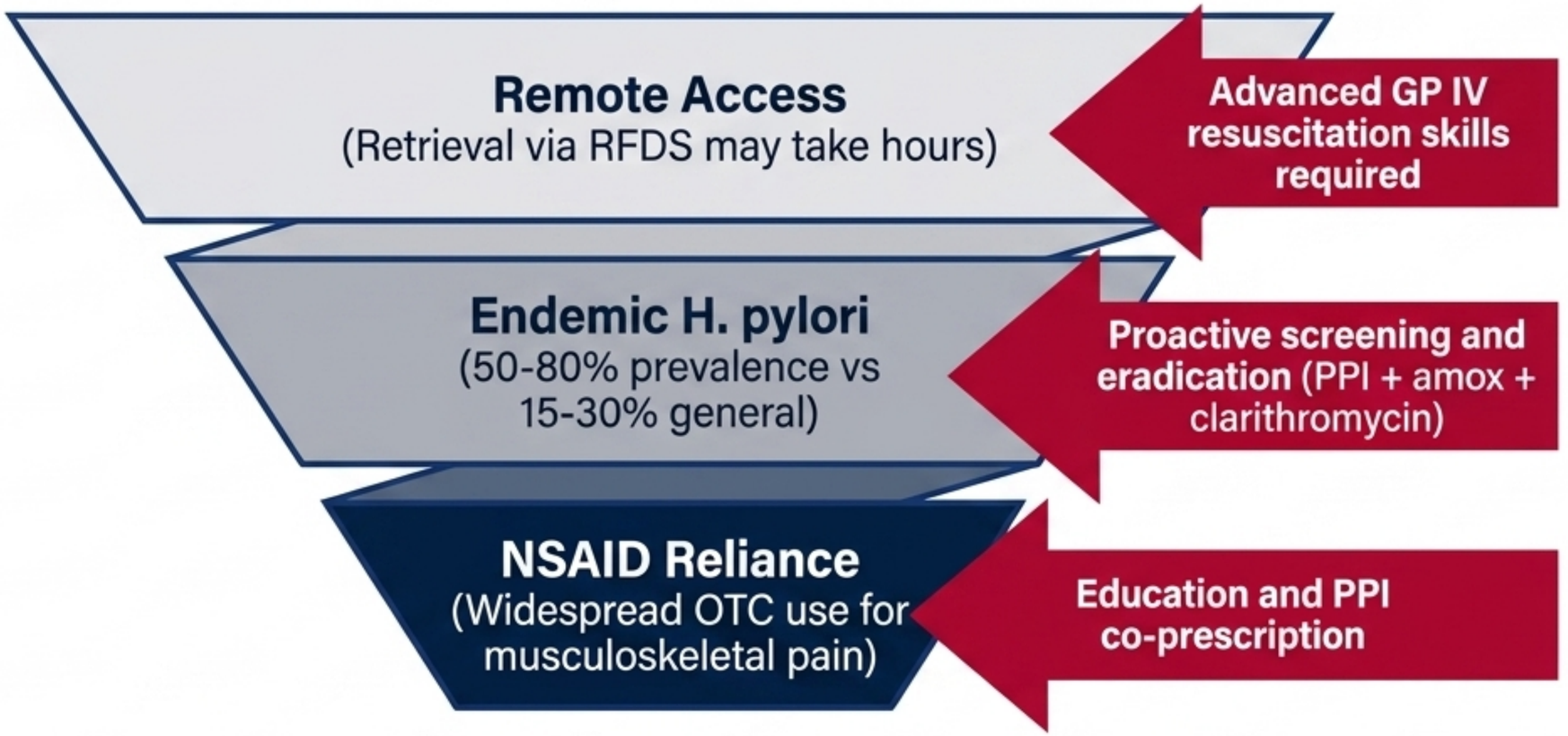
Renal Impairment

- Uraemic platelet dysfunction increases bleeding regardless of meds.
- **Dabigatran contraindicated** if **eGFR <30**.

Paediatrics & Pregnancy

- (Paeds) Tachycardia is earliest sign, **decompensate abruptly**. **20mL/kg** fluid bolus.
- (Pregnancy) **Left lateral tilt** (≥15°) to avoid **aortocaval compression**.

Compounding risks in Aboriginal & Torres Strait Islander health



Ensure culturally safe assessment. Involve an Aboriginal Health Worker (AHW) for intimate exams (rectal/melaena) and coordinate community follow-up.

The definitive triage decision matrix

Clinical Presentation	Synthesized Action Bundle
Haemodynamically Unstable	**Call 000 immediately. 2x large-bore IVs. 1L NaCl bolus.** GXM 2-4 units. NBM.
Stable + Melaena	**Urgent transfer (<30m).** 1x large-bore IV. **500mL NaCl.** Orthostatic check.
Known Cirrhosis + Bleed	**Emergent transfer to tertiary (hepatology). Permissive hypotension** (SBP 80-90).
On Warfarin + Active Bleed	**Urgent transfer.** Cease Warfarin. Draw **FBC/INR/GXM.** (Hospital will give Vit K + PCC).
On DOAC + Active Bleed	**Urgent transfer. Cease DOAC. Note exact time of last dose.** (Hospital will administer specific reversal agents).

Time to endoscopy dictates survival.

The primary care physician's mandate is not diagnosis, but **preservation. Recognize the severity**, restore the volume, and transfer to definitive haemostasis.

Synthesized from Med2Date Clinical Guidelines: Acute GI Bleeding Primary Care Interface (2026).
Always cross-reference with current Therapeutic Guidelines.