NICE National Institute for Health and Care Excellence

2018 surveillance of acute upper gastrointestinal bleeding in over 16s: management (NICE guideline CG141)

Surveillance report

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Contents

Surveillance decision 3

Reasons for the decision 3

Overview of 2018 surveillance methods 5

Evidence considered in surveillance 5

Ongoing research 6

Intelligence gathered during surveillance 6

Equalities 9

Overall decision 9

Surveillance decision

We will not update the guideline on acute upper gastrointestinal bleeding.

We considered this guideline alongside related guidelines.

We will not update the following guideline:

- Gastro-oesophageal reflux disease in children and young people: diagnosis and management (NICE guideline NG1)

We will update the following guideline:

- Barrett's oesophagus: ablative therapy (NICE guideline CG106)

See the webpages for each guideline for the surveillance decisions for these guidelines.

Reasons for the decision

Risk assessment tools

New evidence was identified on tools for assessing risk of poor outcomes after acute upper gastrointestinal bleeding (mainly AIMS65, Blatchford score and Rockall score). Evidence indicated that no tool appears to be sufficient to be used alone; which is consistent with the current recommendation to use both the Blatchford score and the Rockall score after endoscopy.

Resuscitation and initial management

Evidence on resuscitation and initial management was generally consistent with current recommendations. Two randomised controlled trials suggested benefits of tranexamic acid after acute upper gastrointestinal bleeding. Effects were not consistent across outcomes, and no effect on mortality was seen. We are awaiting results of the ongoing Haemorrhage alleviation with tranexamic acid – intestinal system (HALT-IT) study. This National Institute for Health Research (NIHR)-funded trial aims to study the effects of tranexamic acid in 12,000 people with acute gastrointestinal bleeding. When results from this study are

published, the impact on the guideline will be assessed.

Oral versus intravenous proton pump inhibitors (PPIs)

We found several studies comparing oral and intravenous administration of PPIs for non-variceal bleeds. Overall, little difference between the methods was found, although results were inconsistent between studies. Therefore, we decided that the case was not strong enough for an update to cover routes of administration for PPIs at this time.

Variceal bleeding

A large number of new studies covering various interventions, comparators and outcomes for variceal bleeding were identified. Results were inconsistent across interventions and outcomes. However, overall, band ligation and transjugular intrahepatic portosystemic shunts (TIPS) appear to be effective for oesophageal varices. Similarly, cyanoacrylate and TIPS appear to be effective for gastric varices. These findings support current recommendations for treating variceal bleeding. There was no strong indicator of a need to update to consider other interventions for variceal bleeding.

Stress ulcer prophylaxis

Evidence indicated that stress ulcer prophylaxis appears to reduce gastrointestinal bleeding, and there was no consistent evidence of increased infections, a potential adverse event noted to be of concern. These findings support the current recommendations to offer acid suppression therapy as stress ulcer prophylaxis in people admitted to critical care.

We are awaiting results of the ongoing Stress ulcer prophylaxis in the intensive care unit (SUP-ICU) study. This aims to study the effects of stress ulcer prophylaxis in more than 3,000 people with acute gastrointestinal bleeding. When results from this study are published, we will assess the impact on the guideline.

For further details and a summary of all evidence identified in surveillance, see appendix A.

Overview of 2018 surveillance methods

NICE's surveillance team checked whether recommendations in acute upper gastrointestinal bleeding in over 16s: management (NICE guideline CG141) remain up to date.

The surveillance process consisted of:

- Initial feedback from topic experts via a questionnaire.
- Input from stakeholders on known variations in practice and policy priorities.
- Literature searches to identify relevant evidence.
- Assessing the new evidence against current recommendations and deciding whether or not to update sections of the guideline, or the whole guideline.
- Consulting on the decision with stakeholders, except if we propose to update and replace the whole guideline.
- Considering comments received during consultation and making any necessary changes to the decision.

For further details about the process and the possible update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Evidence considered in surveillance

Search and selection strategy

We searched for new evidence related to the whole guideline. We found 68 studies in a search for randomised controlled studies, systematic reviews and observational studies published between 1 April 2016 and 7 June 2018.

We also included a total of 18 studies identified by search in previous surveillance in 2016 and the 2014 evidence update.

From all sources, we considered 86 studies to be relevant to the guideline.

See appendix A: summary of evidence from surveillance for details of all evidence considered, and references.

Ongoing research

We checked for relevant ongoing research; of the ongoing studies identified, 2 studies were assessed as having the potential to change recommendations; therefore we plan to check the publication status regularly, and evaluate the impact of the results on current recommendations as quickly as possible. These studies are:

- Haemorrhage alleviation with tranexamic acid – intestinal system (HALT-IT)
- Stress ulcer prophylaxis in the intensive care unit (SUP-ICU)

Intelligence gathered during surveillance

Views of topic experts

We sent questionnaires to 8 topic experts and received 2 responses. The topic experts either:

- participated in the guideline committee who developed the guideline
- were recruited to the NICE Centre for Guidelines Expert Advisers Panel to represent their specialty.

Topic experts highlighted the ongoing HALT-IT trial, which we will check regularly for publication.

Topic experts drew attention to a topical haemostatic known as Hemospray. One small study in 86 people suggested benefit of Hemospray plus endoscopy compared with endoscopy alone. However, Hemospray is delivered by endoscopy, so if it was used as in the trial, it would lead to an additional endoscopic procedure. Its role in UK practice is unclear because the study did not assess Hemospray compared with, or added to, other treatments delivered at endoscopy.

The guideline investigated the balance between the risks of continuing aspirin treatment (increased risk of bleeding and prolonging bleeding) and the risks of stopping aspirin (stroke or myocardial infarction). It recommended continuing low-dose aspirin in patients in whom haemostasis has been achieved. Topic experts suggested that aspirin may be withheld for a few days after upper gastrointestinal bleeding in some services in the UK. This suggests that the recommendation may not be fully followed. However, we did not identify any evidence that could improve adherence to the recommendation.

Topic experts additionally suggested that the guideline should cover use of non-vitamin K oral anticoagulant drugs. In terms of resuscitation and initial management, no new evidence was identified. Although 1 new drug treatment (idarucizumab) is available, it has a fairly restricted licence and inhibits only 1 of the available the non-vitamin K oral anticoagulant drugs (dabigatran). Therefore, the appropriate treatment for most patients on these drugs would remain blood products such as platelets as currently recommended by the guideline. NICE has published advice on reversal of the anticoagulant effect of dabigatran: idarucizumab (ESNM73). This summarises the evidence for use of idarucizumab, which is licensed for rapid reversal of dabigatran, for example, for emergency surgery or urgent procedures, or in life-threatening or uncontrolled bleeding.

In terms of control of rebleeding and restarting drugs that inhibit blood clotting, the guideline assessed the antiplatelet agents aspirin and clopidogrel because their irreversible inhibition of platelets means that their action lasts for around 10 days after stopping treatment. Evidence identified in surveillance suggested that the benefits of continuing oral anticoagulants (warfarin or the non-vitamin K oral anticoagulant dabigatran) after a major bleeding event, including upper gastrointestinal bleeds, outweigh the risks of future bleeds. The new evidence did not report on the length of time between the bleed and restarting oral anticoagulants. Therefore, updating recommendations to include advice on anticoagulants was not thought to be necessary at this time.

Views of stakeholders

Stakeholders are consulted on all surveillance decisions except if the whole guideline will be updated and replaced. Because this surveillance decision was to not update the guideline, we consulted on the decision.

Overall, 5 stakeholders commented. Two stakeholders represented government organisations, 2 represented medical societies, and 1 represented a hospital.

Three stakeholders provided a general response that they had no comments. One stakeholder agreed with the decision not to update the guideline and had no additional comments on the scope or equalities issues.

One stakeholder disagreed with the decision to not update the guideline. The stakeholder thought that the guideline should address the following issues.

Restrictive blood transfusion

The stakeholder suggested an update was needed to cover restrictive blood transfusion strategies. The guideline already recognises that over-transfusion may be as damaging as under-transfusion.

Use of fibrin or thrombin for non-variceal upper gastrointestinal bleeding

The stakeholder suggested that evidence was poor for the recommendation to use fibrin or thrombin with adrenaline as an option for endoscopic therapy of non-variceal bleeding. The guideline committee recognised that evidence in this area was of low or very low quality, and the suitability of the 3 recommended methods may change depending on the characteristics of the ulcer. No new evidence that could inform an update in this area was identified.

Use of oesophageal stents in bleeding oesophageal varices

The stakeholder suggested that oesophageal stents should be covered by the guideline. No randomised controlled trials of oesophageal stenting were identified during guideline development, so no recommendations could be made. Surveillance identified a small randomised controlled trial of in 28 people. However, NICE interventional procedures guidance on oesophageal stenting already recommends this procedure with normal arrangements.

Use of thrombin in bleeding gastric varices

The stakeholder suggested that the guideline should cover the use of thrombin in bleeding gastric varices. The guideline sought evidence on both thrombin and glue (N-butyl-2-cyanoacrylate or fibrin) as methods of stopping bleeding by forming a plug for treating bleeding gastric varices. However, no studies of thrombin were identified. Surveillance has not identified any new studies assessing thrombin in gastric varices.

Therefore, no update in this area is needed.

See appendix B for full details of stakeholders' comments and our responses.

See ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual, for more details on our consultation processes.

Equalities

No equalities issues were identified during the surveillance process.

Overall decision

After considering all evidence and other intelligence and the impact on current recommendations, we decided that no update is necessary.

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