**Gastroenterology Presentations to Emergency Department**

**in setting of COVID-19 pandemic**

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**Rationale**

* Minimise time of patient being in ED to reduce load on ED and exposure to COVID-19
* Improve decision making to reduce time in ED and divert to ward management or outpatient management and follow-up, where safe and possible
* Early communication with Endoscopist-on-call to direct management, investigations and disposition of patient
* Reduce load on GPs after discharge who have less access to Hospital results. GPs likely will have increased workload due to COVID-19 and are probably under resourced and with minimal support structure
* Reduce load of Outpatient Clinics as this is also resource poor and to minimise patient visits to Hospital/Crowded setting
* Maximise use of Endoscopists who will have more availability due to cancelling of non-urgent (non <30day) endoscopies
* A list of common GI presentation and management scenarios are outlined below.

**Foreign Body Oesophagus**

* **This is not an ENT presentation**-if there are airway issues eg stridor, cyanosis, respiratory compromise, then it is an anaesthetic emergency
* **Call Endoscopist-on-Call at presentation to Triage RN.** Most patients that present have had the obstruction for many hours. Measures such as glucagon and swallowed “Coke” have no evidence and waste time.
* **Don’t Xray-**imaging won’t show most oesophageal FB-the investigation and treatment of choice is rapid endoscopy
* **Prepare patient for Operating Theatre**
* **FB spontaneously passed**-phone Endoscopist-on-call to confirm plan and email referral to \*.\*health.nsw.gov.au

**Upper GI Bleed** –(haematemesis and/or melaena)

* **Transfer to ED acute ward** - assess haemodynamics with conscious state, peripheral perfusion, BP and HR
* **IVI access with large bore cannula (1-2)**-obtain blood for FBC, EUC, coags, LFTs, Group and Hold
* **Volume resuscitation as indicated**
* **Reversal of anticoagulation as appropriate**
* **Call Endoscopist-on-call early**-to coordinate possible OT, infusions (eg PPI,octreotide) Discharge of low risk patients (calculate the Glasgow-Blatchford score): phone Endoscopist on call to confirm plan and email referral to \*.\*health.nsw.gov.au

**Lower GI Bleed** –(bright red or plum coloured blood, not melaena)

* **Transfer to ED acute ward** - assess haemodynamics with conscious state, peripheral perfusion, BP and HR
* **Volume resuscitation as indicated**
* **Reversal of anticoagulation as appropriate**
* **CT angiography is not indicated** in most patients. Lower GI bleeds mostly settle without intervention, elective colonoscopy is arranged later to identify pathology. Persistently unstable patients may need urgent CT angiography but decision should be made by Endoscopist-on-call
* **Stable and low volume lower GI bleed**-eg suspected haemorrhoids, resolved bleeding: phone Endoscopist on call to confirm plan and email referral to \*.\*health.nsw.gov.au

**Acute Diarrhoea**

* **Infectious causes are most likely**-consider PPE and isolation of patient
* **Assess haemodynamics** with conscious state, peripheral perfusion, BP and HR
* **Volume resuscitation as indicated**
* **Vomiting patients-**Ondansetron 4-8mg via sublingual wafer or IVI at presentation, paracetamol IVI if febrile/abdo pains
* **Faeces collection**-yellow or brown top jar and order PCR for common bacteria and clostridium. PCR is much more sensitive and quicker result than culture (but order M+C+S as well).
* **Admit if**-
  + Persistently unable to maintain oral hydration: admit under Gastroenterologist and transfer to the ward
  + Bloody diarrhoea
  + Sepsis/New kidney impairment
  + Persistent abdo pain
  + **Don’t order CT abdomen**-it rarely changes management in acute diarrhoea and wastes time/money and is potentially dangerous if IVI contrast is given
* **Lower threshold to admit-**
  + Elderly
  + Immunosuppressed
  + Diabetic
  + No carers available
* **Discharge antibiotics**-usually not indicated but if diarrhoea>3days or unwell consider Azithromycin 1g stat or Ciprofloxacin 500mg bd for 5days. Consider possibility of Clostridium difficile where metronidazole or vancomycin 125mg oral qid would be given. Phone Endoscopist on call to confirm plan and email to \*.\*health.nsw.gov.au

**Iron deficiency Anaemia** -without current upper or lower GI bleeding

* **Outpatient Management**-unless severely symptomatic. Elective Iron infusion (if oral iron has failed/not been tolerated) can be arranged: phone Endoscopist on call to confirm plan and email referral to \*.\*health.nsw.gov.au.
* Blood transfusion only if marked symptoms, lower threshold if comorbities. Refer to Australian Red Cross Blood Transfusion Service or iTransfuse App. Early transfer to ward under Gastroenterologist if admission is necessary. If to be discharged: phone Endoscopist-on-call to confirm plan and email referral to \*.\*health.nsw.gov.au

**Non-Surgical Abdominal Pain**

* Consider surgical opinion if persistent signs or severe symptoms. As per TSH Guideline: a CT abdomen can only be ordered after personal review of the abdomen by the Surgical Registrar. If the Surgical Registrar is in OT or at a Ward Emergency, then CT can be ordered by ED staff. The patient will be admitted to the ward under the care of the relevant specialty (Andrew Finckh, ED Director)
* **AXR rarely changes management**-it is an insensitive and nonspecific test and wastes time and money. If small bowel obstruction is suspected-proceed directly to CT abdomen in consultation with surgical team
* **Rapid bloods**-EUC,LFTs,FBC,lipase/CRP
* **Bedside Ultrasound**-where available to identify biliary disease
* **Outpatient trial of PPI** such as Rabeprazole 20mg daily 30-60minutes before meal to be considered
* Avoid use of opiates eg Endone to achieve early discharge as potential to develop dependence
* Avoid aspirin/NSAIDs
* Keep Nil by Mouth or clear fluids only if admitted to allow for early endoscopy
* If plan for discharge via Gastroenterologist- phone Endoscopist on call to confirm plan and email referral to \*.\*health.nsw.gov.au