Monitoring: Suspected variceal or high risk bleed needs continuous monitoring HR BP RR. AVPU at regular intervals. Reasess Sheffield Score if status changes.

Progression

Do not delay in working through flow chart. Proceed with management where possible whilst awaiting results.

Any child vomiting any blood

Assess & Manage ABC
Keep NBM
IV Access
Fluid / blood bolus and 2 large cannlulae if shocked.
Consider major haemorrhage protocol.

Peform URGENT CXR to Check for button battery unless ingestion can confidently be excluded.

Button battery present above diaphragm Arrange Emergency removal. (usually by ENT or paed surgeon)
Large Cannula X 2 Crossmatch and FBC, Coagulation, U+E, blood gas

No button battery apparent

Assess likelihood of portal hypertension:
Enlarged liver, spleen, history of liver disease
Bloods: FBC, Coagulation, Group and save, LFT, U+Es
IV omeprazole
Urgent US abdomen

If uncontrollable bleeding use Foley Catheter or Sengasten Blakemore tube to tamponade oesophageal bleeding (insert then inflate balloon)

Portal Hypertension likely
Enlarged spleen +/- liver de-arranged LFTs. Known liver disease or portal hypertension.
Discuss with variceal bleeding centre and follow guidance
IV Antibiotics and octreotide, correct coagulopathy.
Uncontrollable bleeding use Sengstaken Blakemore tube or foley catheter to tamponade bleeding

Portal hypertension unlikely
Assess risk eg with Sheffield Score. More detailed history of bleeding.

High risk: requires urgent endoscopy with endoscopist and surgeon able to manage acute bleeding. Consider octreotide and tranexamic acid to control bleeding. **Consider transport discuss with PICU transport team**

Low risk: Endoscopy not urgent. Can remain in local centre and discuss further management with Paed endoscopist after considering other reasons for reported blood eg epistaxis.