

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.

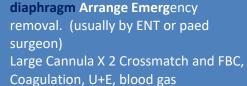


Peform URGENT CXR to

Check for button battery unless ingestion can confidently be excluded.



No button battery apparent



Button battery present above



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



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



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



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.