2026.08.12. 소화기내과 북리딩

Endoscopic diagnosis and management of peptic ulcer bleeding: European Society of Gastrointestinal Endoscopy(ESGE) Guideline Update 2026

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Guideline scope

- 2021 nonvariceal UGIH guideline을 업데이트

- Nonvariceal UGIH : gastric and duodenal peptic ulcers, Mallory–Weiss syndrome, Dieulafoy's lesion, malignancy, angioectasias, and mucosal erosive disease of the esophagus, stomach, duodenum

- 범위: peptic ulcer hemorrhage의 pre-endoscopy, endoscopy, post-endoscopy management

Pre-endoscopy management

◆ Initial patient evaluation and hemodynamic resuscitation

- Immediate assessment of hemodynamic status
- If hemodynamic instability, prompt intravascular volume replacement, initially using crystalloid fluids

  => Hemodynamic instability ? SBP < 90 mmHg alone, and SBP < 100 mmHg with HR >100/min

  => Significantly decrease mortality

◆ RBC Transfusion

- Hemodynamically stable + no cardiovascular disease
- Hb <7 g/dL → RBC transfusion (Target Hb 7–9 g/dL)

- Hemodynamically stable + acute/chronic cardiovascular disease
- Hb ≤8 g/dL → RBC transfusion (Target Hb ≥10 g/dL)

Pre-endoscopy management

◆ Pre-endoscopy risk stratification

- Glasgow–Blatchford Score (GBS)

  => Pre-endoscopy risk stratification for acute UGIH

  => GBS ≤1 → : Outpatient management + outpatient endoscopy

  => Prompt GI/endoscopy follow-up plan

◆ Do not recommend the routine use of video capsule endoscopy or telemetric blood-sensing capsules in the management of patients with suspected UGIH

Pre-endoscopy management

◆ Antiplatelet / Anticoagulant management

• Aspirin

=> Primary cardiovascular prevention : Hold and restart after careful re-evaluation

=> Secondary cardiovascular prevention : Do not hold. If interrupted, aspirin should be restarted as soon as possible, preferably within 3–5days

=> DAPT for secondary prevention: Hold second antiplatelet agent, restart as soon as possible, preferably within 5days

=> Consider Cardiology consultation

• Do not recommend routine platelet transfusion for patients with acute non variceal UGIH taking antiplatelet agents

• Do not recommend the use of tranexamic acid

Pre-endoscopy management

◆ Antiplatelet / Anticoagulant management

- VKA

=> Hold VKA

=> Hemodynamic instability : low-dose vitamin K + IV PCC/FFP

=> Reversal should not dely endoscopy/hemostasis

- DOAC

=> Hold DOAC, but do not delay endoscopy

=> Severe ongoing bleeding : DOAC reversal agent or IV PCC

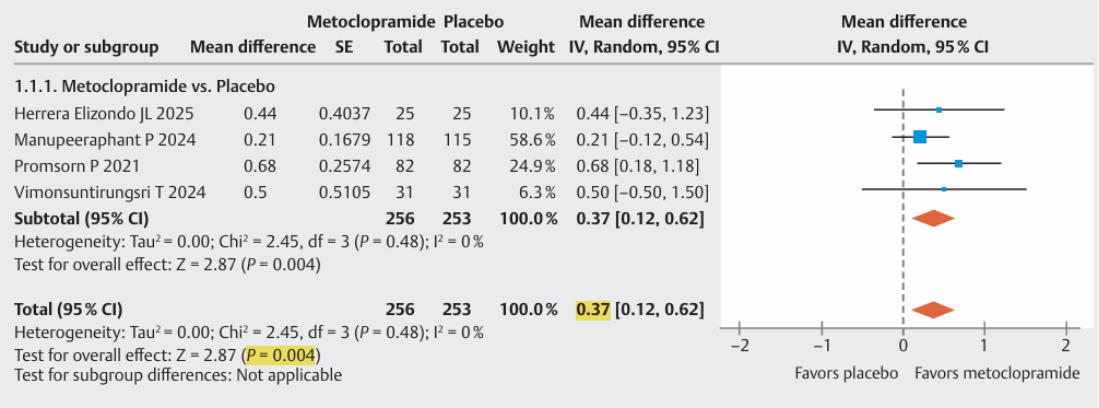
Pre-endoscopy management

◆ Prokinetic medications

- Severe/ongoing active UGIH : IV erythromycin, IV metoclopramide

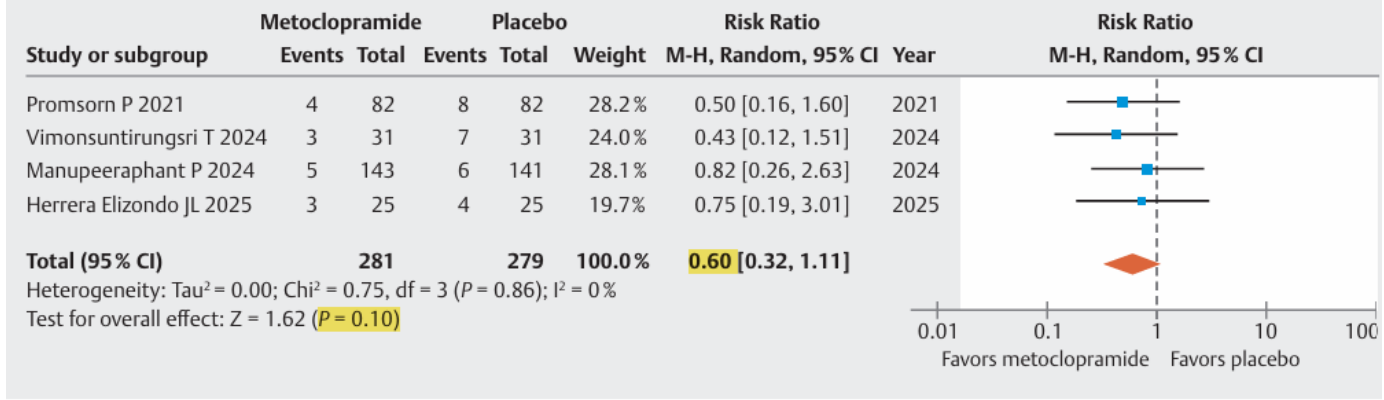
=> Improved mucosal exposure and endoscopic visualization

=> No significant differences in units of blood transfused or hospital length of stay, although there was a possible trend toward a reduced need for second-look endoscopy



Study or subgroup	Mean difference	SE	Metoclopramide Total	Placebo Total	Weight	Mean difference IV, Random, 95% CI
1.1.1. Metoclopramide vs. Placebo						
Herrera Elizondo JL 2025	0.44	0.4037	25	25	10.1%	0.44 [−0.35, 1.23]
Manupeeraphant P 2024	0.21	0.1679	118	115	58.6%	0.21 [−0.12, 0.54]
Promsorn P 2021	0.68	0.2574	82	82	24.9%	0.68 [0.18, 1.18]
Vimonsuntirungsri T 2024	0.5	0.5105	31	31	6.3%	0.50 [−0.50, 1.50]
Subtotal (95% CI)			**256**	**253**	**100.0%**	**0.37 [0.12, 0.62]**
Heterogeneity: Tau² = 0.00; Chi² = 2.45, df = 3 (P = 0.48); I² = 0%						
Test for overall effect: Z = 2.87 (P = 0.004)						
Total (95% CI)			**256**	**253**	**100.0%**	**0.37 [0.12, 0.62]**
Heterogeneity: Tau² = 0.00; Chi² = 2.45, df = 3 (P = 0.48); I² = 0%						
Test for overall effect: Z = 2.87 (P = 0.004)						
Test for subgroup differences: Not applicable						

▶ **Fig. 1** Effect of metoclopramide vs. placebo regarding adequate mucosal exposure.



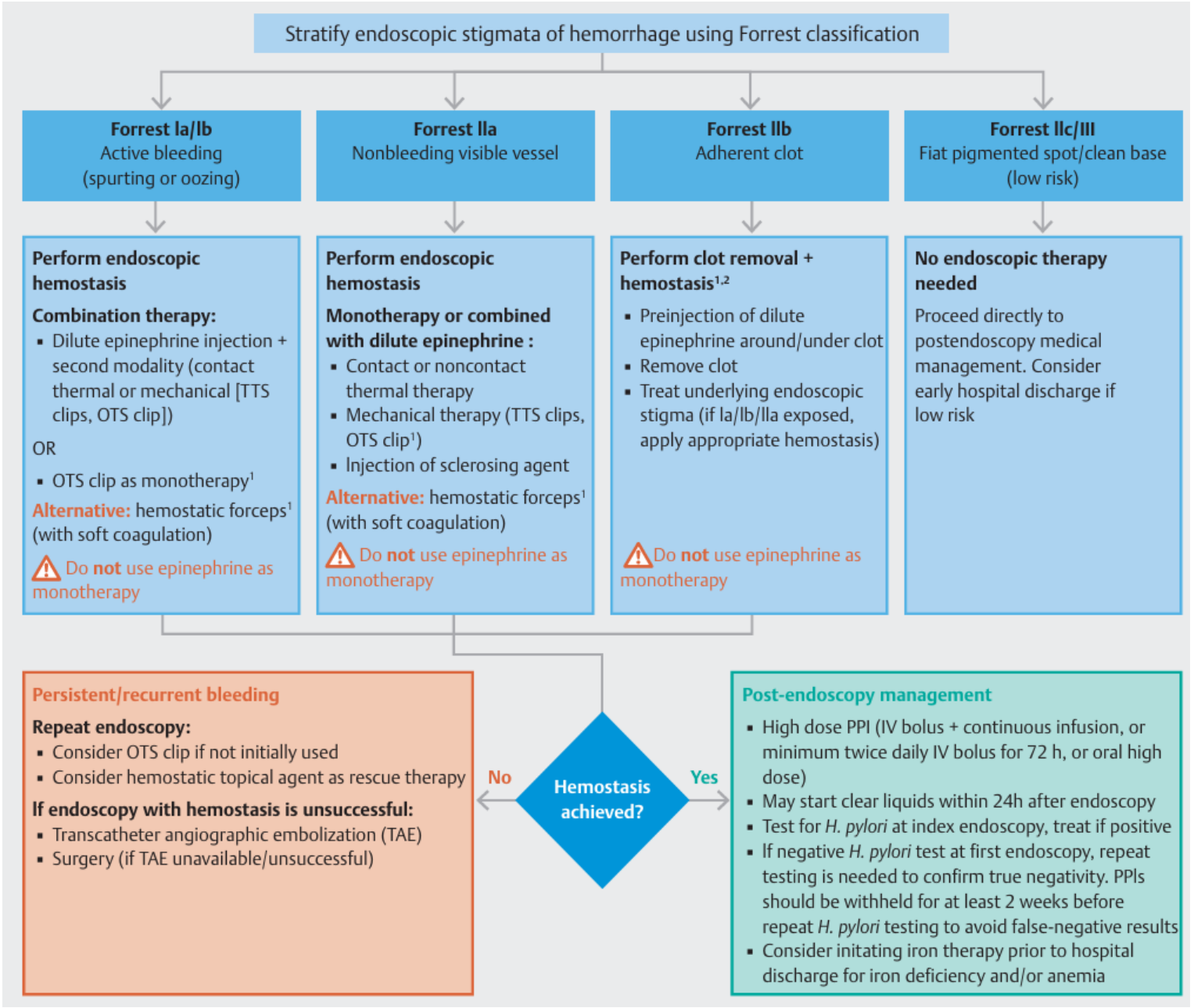
Study or subgroup	Metoclopramide Events	Total	Placebo Events	Total	Weight	Risk Ratio M-H, Random, 95% CI	Year
Promsorn P 2021	4	82	8	82	28.2%	0.50 [0.16, 1.60]	2021
Vimonsuntirungsri T 2024	3	31	7	31	24.0%	0.43 [0.12, 1.51]	2024
Manupeeraphant P 2024	5	143	6	141	28.1%	0.82 [0.26, 2.63]	2024
Herrera Elizondo JL 2025	3	25	4	25	19.7%	0.75 [0.19, 3.01]	2025
Total (95% CI)		**281**		**279**	**100.0%**	**0.60 [0.32, 1.11]**	
Heterogeneity: Tau² = 0.00; Chi² = 0.75, df = 3 (P = 0.86); I² = 0%							
Test for overall effect: Z = 1.62 (P = 0.10)							

▶ **Fig. 2** Effect of metoclopramide vs. placebo regarding requirements for second-look endoscopy.

Endoscopy management

◆ Timing of upper GI endoscopy

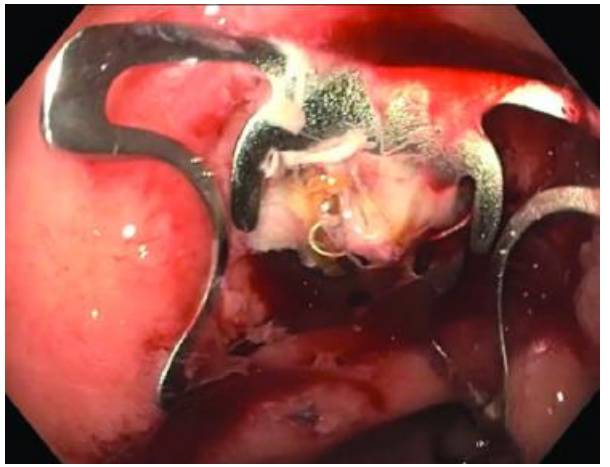
- Emergent: ≤6 h, Urgent: ≤12 h, Early: ≤24 h, Delayed: >24 h
- Early endoscopy after adequate hemodynamic resuscitation
- Do not recommend routine emergent or urgent endoscopy unless the patient remains hemodynamically unstable despite adequate resuscitation
- Use of antiplatelet/anticoagulant, predetermined INR cutoff : should not be used to guide the timing of endoscopy



Endoscopy management

◆ Forrest Ia/Ib

- Dilute epinephrine injection + second hemostatic modality
  – contact thermal or mechanical therapy (TTS clip / OTS clip)



- OTS clip monotherapy : first-line alternative
  =>Lower risk of further bleeding at 30 days compared with standard endoscopic therapy
- Hemostatic forceps + soft coagulation : monotherapy option
- Do not recommend topical hemostatic agents as first-line therapy for high risk peptic ulcer bleeding
- Do no use epinephrine injection as monotherapy

Endoscopy management

◆ Forrest IIa

- monotherapy or combine with epinephrine

=> Contact thermal therapy, Noncontact thermal therapy, Mechanical therapy(TTS clip, OTS clip), Sclerosing-agent injection

◆Forrest IIb

- Remove clot, check underlying stigma

=> Ia/Ib/IIa → hemostasis (O), IIc/III → hemostasis (X)

- Pre-injection of diluted epinephrine around and/or under the clot should be performed before attempting clot removal to mitigate the risk of inducing brisk bleeding

Use of a DEP to guide hemostatic therapy was associated with a significant reduction in recurrence of bleeding, surgical intervention, and bleeding-associated mortality

=>ESGE could not reach a recommendation for or against the routine use of a DEP

Endoscopy management

◆ Persistent/Recurrent bleeding

- Ongoing active bleeding (spurting, arterial pulsatile bleeding, or oozing) that is present at the end of the first endoscopy and refractory to standard hemostasis modalities.
- Bleeding after initial successful endoscopic hemostasis

=>Consider topical hemostatic agent or OTS clip

=>Consider TAE(trans catheter angiographic embolization)

=>Surgery

◆ Prophylactic TAE

- Selected high-risk peptic ulcer bleeding
  - initial hemodynamic instability
  - posterior duodenal wall ulcer
  - large ulcer >2 cm
  - durable endoscopic hemostasis is considered uncertain

Postendoscopy management

◆ High dose PPI & second-look

- After endoscopic hemostasis or FIIb ulcer stigmata not treated endoscopically
- IV bolus + continuous infusion (80 mg bolus → 8 mg/h) for 72 hours

  => High-dose IV bolus twice daily or high-dose oral formulation twice daily
- ESGE could not reach a consensus for or against the routine use of P-CAB for patients who have undergone endoscopic hemostasis
- Do no recommend routine second-look endoscopy

Endoscopy management

◆ H. pylori, anticoagulation, iron, nutrition

• H. pylori

=>Investigate in Index endoscopy and HPE

=>Retest if Index test negative (hold PPI at least two weeks)

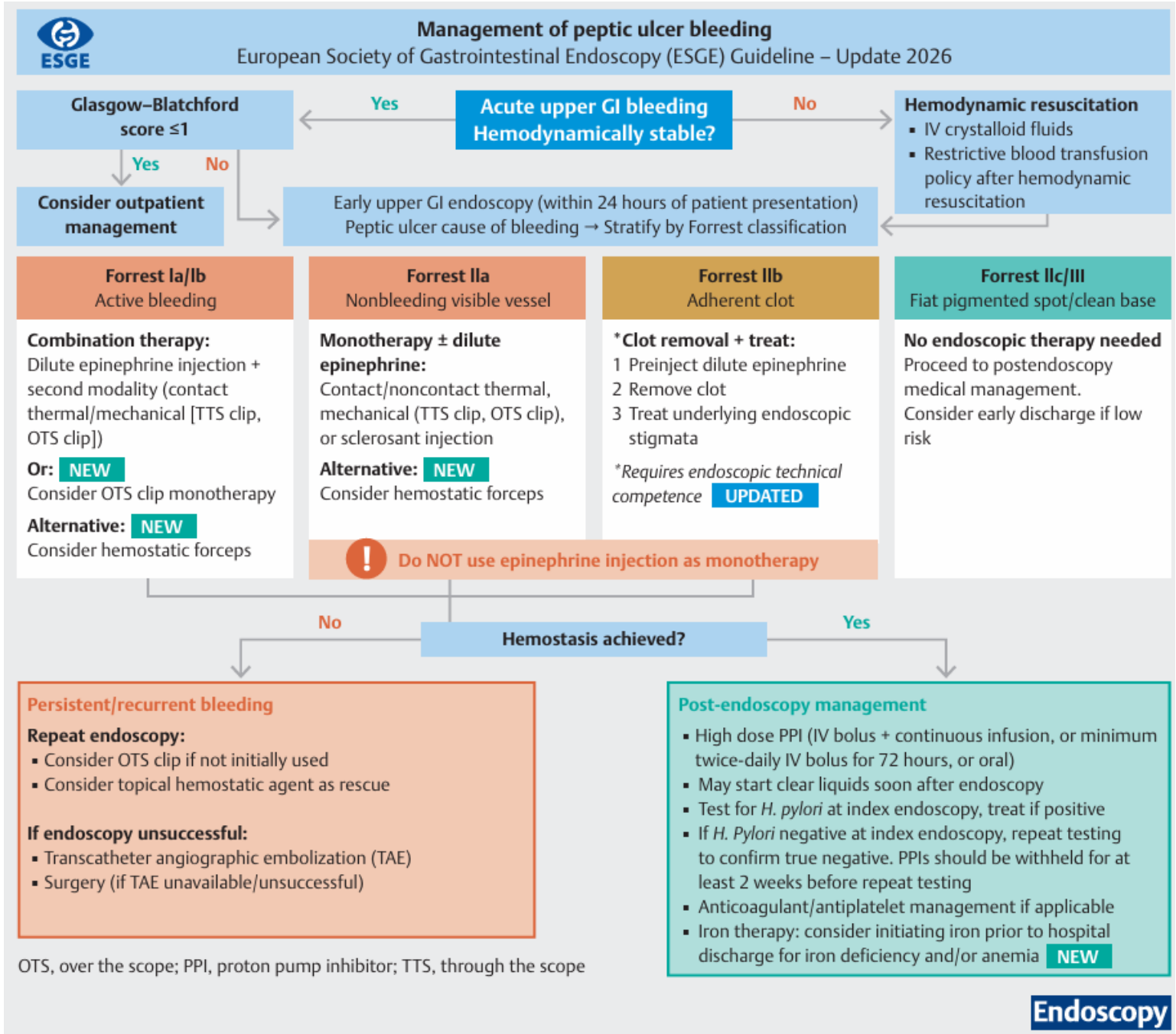
• Anticoagulation

=> Resume as soon as clinically indicated based on thromboembolic risk (CHA2DS2-VASc, HAS-BLED)

=> VKAs should be restarted earlier because the time required to achieve adequate anticoagulation is longer (up to 5days) compared with DOACs, which take hours

• Consider initating iron therapy prior to hospital discharge for iron deficiency and/or anemia

• Start early oral nutrition within 24 hours


ESGE
Management of peptic ulcer bleeding
European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2026
Acute upper GI bleeding Hemodynamically stable?
Yes
No
Glasgow–Blatchford score ≤1
Yes
No
Consider outpatient management
Hemodynamic resuscitation
IV crystalloid fluids
Restrictive blood transfusion policy after hemodynamic resuscitation
Early upper GI endoscopy (within 24 hours of patient presentation)
Peptic ulcer cause of bleeding → Stratify by Forrest classification
Forrest Ia/Ib
Active bleeding
Combination therapy:
Dilute epinephrine injection + second modality (contact thermal/mechanical [TTS clip, OTS clip])
Or: NEW
Consider OTS clip monotherapy
Alternative: NEW
Consider hemostatic forceps
Forrest IIa
Nonbleeding visible vessel
Monotherapy ± dilute epinephrine:
Contact/noncontact thermal, mechanical (TTS clip, OTS clip), or sclerosant injection
Alternative: NEW
Consider hemostatic forceps
Forrest IIb
Adherent clot
*Clot removal + treat:
1 Preinject dilute epinephrine
2 Remove clot
3 Treat underlying endoscopic stigmata
*Requires endoscopic technical competence UPDATED
Forrest IIc/III
Fiat pigmented spot/clean base
No endoscopic therapy needed
Proceed to postendoscopy medical management.
Consider early discharge if low risk
Do NOT use epinephrine injection as monotherapy
Hemostasis achieved?
No
Yes
Persistent/recurrent bleeding
Repeat endoscopy:
Consider OTS clip if not initially used
Consider topical hemostatic agent as rescue
If endoscopy unsuccessful:
Transcatheter angiographic embolization (TAE)
Surgery (if TAE unavailable/unsuccessful)
Post-endoscopy management
High dose PPI (IV bolus + continuous infusion, or minimum twice-daily IV bolus for 72 hours, or oral)
May start clear liquids soon after endoscopy
Test for H. pylori at index endoscopy, treat if positive
If H. Pylori negative at index endoscopy, repeat testing to confirm true negative. PPIs should be withheld for at least 2 weeks before repeat testing
Anticoagulant/antiplatelet management if applicable
Iron therapy: consider initiating iron prior to hospital discharge for iron deficiency and/or anemia NEW
OTS, over the scope; PPI, proton pump inhibitor; TTS, through the scope
Endoscopy