GI Bleeding Core Content

Keith Conover, M.D., FACEP

- Treat as emergency until proven otherwise
- ^ morbidity:
  - hemo unstable
  - rebleeding
  - failure to clear
  - age
  - comorbidity
  - (increased bowel sounds)
- Upper Causes:
  - PUD: duodenal, gastric, stomal 40%
  - esophagitis/gastritis25%
  - varices 20%
  - Mallory-Weiss 5% (this and above 90%)
  - Others:: stress ulcer, AVM, ENT fract, bleeding, AAA repair (rare) 10% total
- Lower caues:
  - Diverticular
  - Angiodysplasia/AVM
  - tumor
  - hemorrhoids
  - polyps
  - IBD/ infectious gastroenteritis
  - AAA repair (AAA repair + GI bleeding = STAT scope)
- PE:
  - ankle petechiae

- **telangectasias on skin: Osler-Weber-Rendu = hereditary hemorrhagic telangiectasia - a disease with onset usually after puberty, marked by multiple small telangiectases and dilated venules that develop slowly on the skin and mucous membranes; the face, lips, tongue, nasopharynx, and intestinal mucosa are frequent sites, and recurrent bleeding may occur; autosomal dominant inheritance ,**
- **melanin spots on fingers or lips or in mouth: Peutz-Jeghers - generalized hamartomatous multiple polyposis of the intestinal tract, consistently involving the jejunum, associated with melanin spots of the lips, buccal mucosa, and fingers; autosomal dominant inheritance**
- **Lots of skin fibromas and cysts: Gardner's - multiple polyposis predisposing to carcinoma of the colon; also multiple tumors, osteomas of the skull, epidermoid cysts, and fibromas; autosomal dominant inheritance.)**

❖ **Labs/Studies:**

- **rectal**
  - **false +: iron, raw meat/veggies/fruits, bromides, iodides**

- false -: charcoal, antacids Mg++, Vit. C (kill the peroxidase)
- Usuals + EKG: silent ischemia
- H/H: Q2Liters, may take "6-12 hours"
- BUN: clue to how much bleeding?
- X-rays? Only if suspect perf.
- NG? (when not? Tintanalli "always" Sell: "I'll kill you if you do") 25% negative in duodenal bleed, less if bile aspirated
- Anoscopy?
- EGD?
- Colonoscopy?
- Angiography?
- RBC scans?

❖ Treatment
- iced lavage?
- lavage?
- somatostatin? octreotide? vasopressin? vasopressin/NTG? with varices? with PUD?
- H2 blockers? does it help acute bleeding? No.
- proton pump inhibitors?
- beta blockers for varices?
- antibiotics?
- Sengstaken-Blakemore tube? intubate them all?

❖ Disposition:

- who goes home? Endoscopy in ED or from ED? H/N:
  - < 75, no bad protoplasm
  - no ascites, portal HTN
  - Normal PT/PTT/Plats
  - Normal BP and not orthostatic
  - NG clears
  - Hg > 10
  - Compliant, close follow-up
- who goes to ICU?
  - Hct < 30 (20) or large drop
  - BP < 100
  - red NG lavage
  - cirrhosis by hx or exam
  - hx of vomiting red blood
- who needs surgical consultation, when?

❖ PUD

- Traditional Risks:
  - tobacco
  - diet? Alcohol? caffeine?
  - stress? trauma?
  - NSAIDs?
- H. pylori?
  - 10-80% whites 30-75, 45% blacks < 25.
  - 95% of duodenal and 80% gastric ulcers infected.
  - Risk for CA
  - What else other than H. pylori? NSAIDs.

- **Dx:**
  - **Bx + CLO "Campylobacter-like organism"($10)/Path ($150)**
  - **IgG ($75) - persists**
  - **Breath test for radio-urease ($250)**

- **Dx PUD in the ED?**
  - **night pain (duodenal), food pain (gastric)**
  - **relieved by food/antacids**
  - **short duration**
  - **radiation pattern**
- **Differential: MI, CAD, GB, pancreas, AAA, GERD, dyspepsia (role of GI cocktail if suspect CAD? Linked angina?)**
- **Workup: rectal? CBC?**
- **Treat:**
  - **H2 blockers? (Not Tagemet, P-450 problems) all same (Pepcid cheapest)**
  - **PPIs? faster, kill H. pylori some**
  - **Sucralfate? No EGD after.**
  - **Cytotec with NSAID?**
  - **Breath test or IgG sent from ED with antibiotics but no EGD? Yes.**
- **Complications: perf, bleed, obstruct**

❖ **Hemorrhoids**

- **Anoscopes (new Mercy one)**
- **If hemorrhoid bleeding, do they need colonoscopy? Yes if over 40.**

- **Excision of thrombosed external hemorrhoids:**
  - **if > 48 hours, hard, painful, no comorbidity**
  - **elliptical:**
    - **easier to get all clots out**
    - **removes redundant tissue**