

GI BLEEDING

INTRODUCTION

- Can be classified as
 - acute or chronic
 - Upper and lower gastrointestinal bleeding

Thus can be divided into

- Acute upper GIT bleeding
- Acute lower GIT bleeding
- Chronic upper GIT bleeding
- Chronic lower GIT bleeding

ACUTE UPPER GIT BLEEDING

- Cardinal symptoms included: haematemesis and melena
- Unaltered blood can appear per rectum after a bleed from the the upper GIT, but usually a massive bleed
- DARK BLOOD AND CLOTS IN STOOL WITHOUT SHOCK IS ALWAYS DUE TO LOWER GIT BLEEDING
- Commonest cause of acute upper GIT bleeding is peptic ulceration
- Other important causes are drugs: mainly NSAIDs. Corticosteroids at usual therapeutic doses do not cause bleeding.

Drugs (NSAIDs) Alcohol

Reflux
oesophagitis (2–5%)

Mallory–Weiss
syndrome (5–10%)

50% { Gastric ulcer
Duodenal ulcer

Varices (10–20%)

Gastric varices

Gastric carcinoma
(uncommon)

Haemorrhagic gastropathy
and erosions (15–20%)

Other uncommon causes

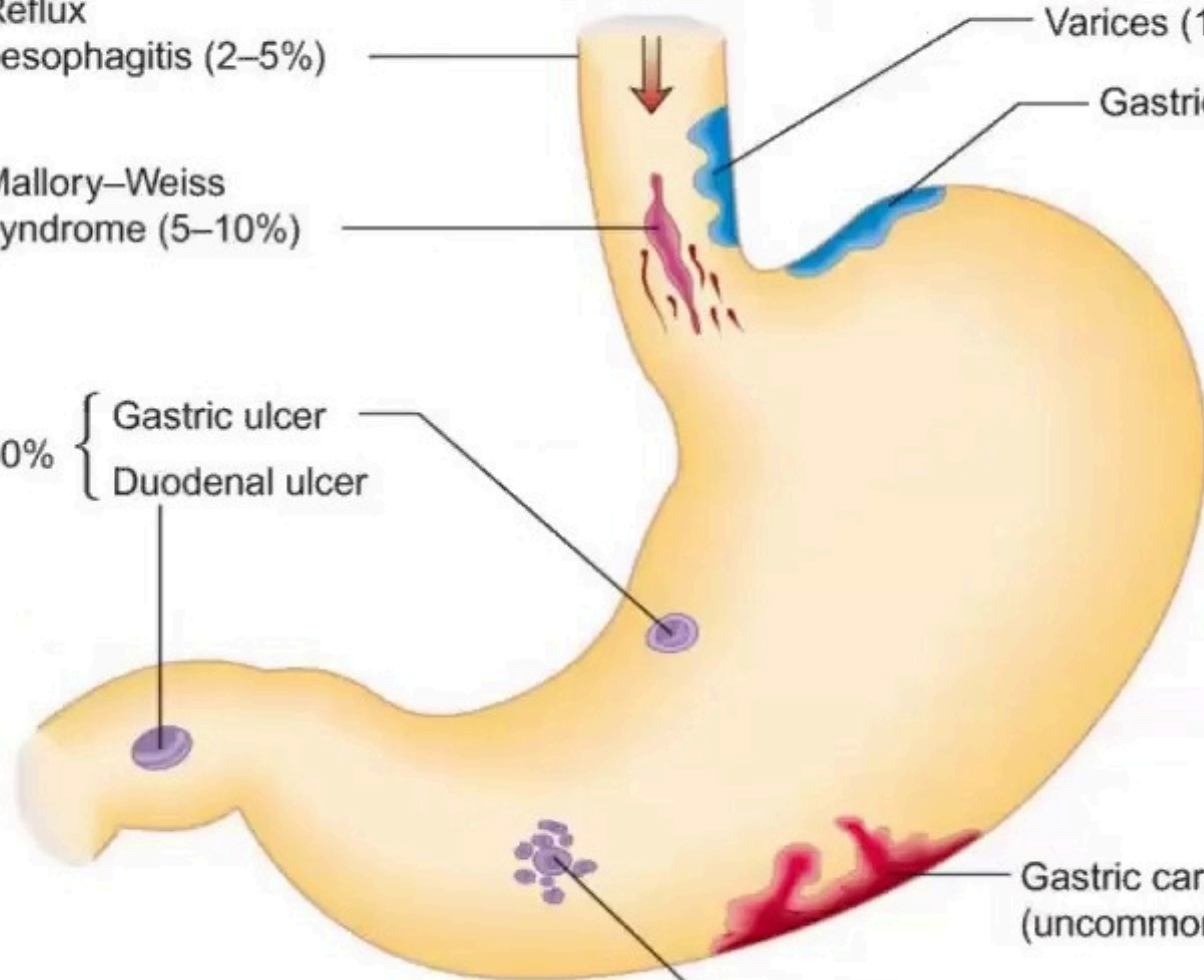
Gastric antral vascular ectasia
(GAVE)

Hereditary telangiectasia
(Osler–Weber–Rendu syndrome)

Pseudoxanthoma elasticum

Blood dyscrasias

Disseminated gastric vascular abnormalities



CLINICAL APPROACH TO THE PATIENT

- All recent history (48hrs) of bleeding should be seen in hospital
- 85% of bleeding will stop spontaneously within 48hrs
- Utilise scoring systems to assess the risk for rebleed

ROCKALL RISK ASSESSMENT SCORE

Rockall risk assessment score in non-variceal upper gastrointestinal haemorrhage

Variable	Score			
	0	1	2	3
Age (years)	<60	60–79	>79	–
Circulation	BP >100 mmHg	BP >100 mmHg	BP <100 mmHg	–
	Pulse <100 b.p.m.	Pulse >100 b.p.m.	Pulse >100 b.p.m.	
Co-morbidity	None	–	Cardiac disease, any other major co-morbidity	Chronic kidney disease, liver failure, disseminated malignancy
Endoscopic diagnosis	Mallory–Weiss tear, no lesion	All other diagnoses	Malignancy of the upper gastrointestinal tract	–
Major SRH	None, or dark spots	–	Blood in the upper gastrointestinal tract, adherent clot or spurting vessel	–

BP, blood pressure (systolic); SRH, stigmata of recent haemorrhage.

THE BLATCHFORD SCORE

The Blatchford score (pre-endoscopy clinical findings)

Variable	Score					
	1	2	3	4	5	6
Blood urea (mmol/L)		≥6.5 to <8.0	≥8.0 to <10.0	≥10.0 to <25.0		≥25.0
Haemoglobin (g/L) for men	≥120 to <130		≥100 to <120			<100
Haemoglobin (g/L) for women	≥100 to <120					<100
Systolic blood pressure (mmHG)	100–109	90–99	<90			
Pulse rate per minute	≥100					
Melaena	Present					
Syncope		Present				
Hepatic disease		Present				
Cardiac failure		Present				

- The following factors affect the risk of rebleeding and death
 - Age
 - Evidence of co-morbidity, e.g cardiac failure, IHD,CKD, and malignancy
 - Presence of the classical clinical features of shock
 - Endoscopic diagnosis
 - Endoscopic stigmata of recent bleeding
 - Clinical signs of CLD

management

- **IMMEDIATE MANAGEMENT**

- Take a history and perform an examination
- Monitor pulse and BP every 30mins
- Take samples for FBC, E/U/Cr, liver biochemistry, coagulation screen, group and CX (2units initially)
- Establish intravenous access- 2 large-bore i.v. cannulae
- Give blood transfusion/colloid if necessary
- Give oxygen
- Perform urgent endoscopy in shocked patient/liver disease
- Continue to monitor pulse and BP
- Re-endoscopy for continued bleeding/hypovolemia
- Arrange surgery if bleeding persist

- ENDOSCOPY

- Will usually diagnose, stratify risk and enable therapy to be performed if needed
 - Should be done as soon as the person is resuscitated.
 - Discharge patients with rockall score of 0 or 1
 - Will detect the cause of haemorrhage in 80% or more of cases
- Consider a Sengstaken Blakemore tube when endoscopy is not available

- At 1st endoscopy
 - Varices should be treated, usually with banding
 - Stenting can be used but is not widely available
 - Bleeding ulcers can be treated using two or three haemostatic methods:
 - Injection with adrenaline
 - Thermal coagulation
 - Endoscopic clipping
 - Haemostatic powders : for more difficult bleeds such as cancer related
 - Dual or triple therapy may be needed

- DRUG THERAPY

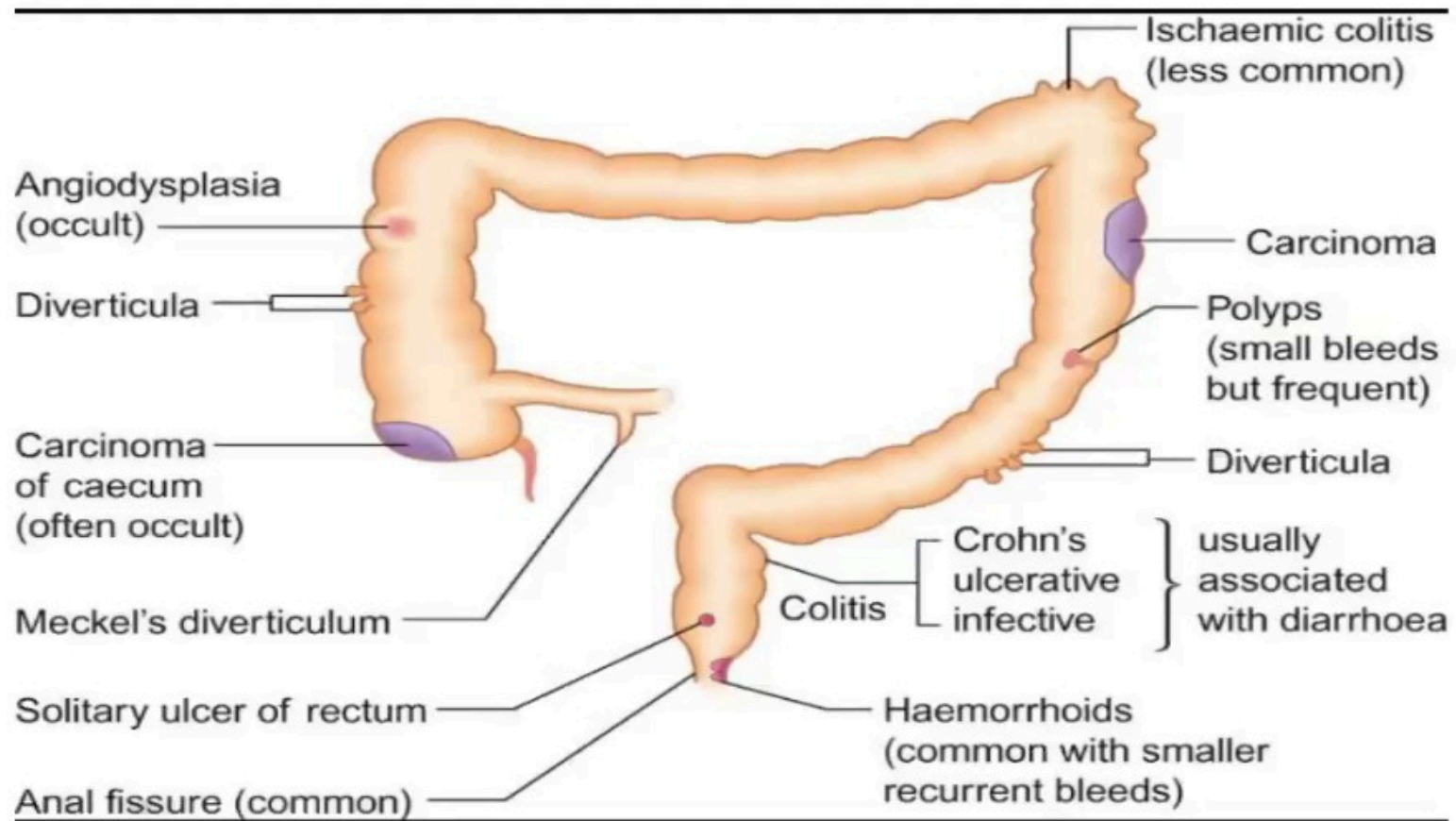
- Intravenous PP, should be given to all patients with active bleeding ulcers

- OTHERS

- Embolisation by an interventional radiologist

ACUTE LOWER GIT BLEEDING

- Massive lower GIT bleeding is rare and is usually due to diverticular disease or ischaemic colitis
- Common causes are haemorrhoids and anal fissures.



MANAGEMENT

- Most will start and stop spontaneously
- Few will need resuscitation same as for upper GIT bleeding
- Investigations
 - Proctoscopy
 - Flexible sigmoidoscopy or colonoscopy
 - Video capsule endoscopy
 - angiography

CHRONIC GIT BLEEDING

- Patient with chronic bleeding present with iron deficiency anaemia
- The primary concern is to exclude cancer, particularly of the stomach or right colon and coeliac disease
- Occult stool tests are unhelpful
- Hookworm is the most common cause of chronic intestinal blood loss worldwide.

DIAGNOSIS

- Upper git endoscopy
- Colonoscopy
- Unprepared CT
- CT colonoscopy
- Capsule endoscopy

MANAGEMENT

- The cause of the bleeding should be found and dealt with
- Oral iron is given to treat anemia
- Fluids and blood transfusion