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/gastritis 25%
  - varices 20%
  - Mallory-Weiss 5% (this and above 90%)
  - Others: stress ulcer, AVM, ENT fract, bleeding, AAA repair (rare) 10% total

- Lower causes:
  - 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/fruit, 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?


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