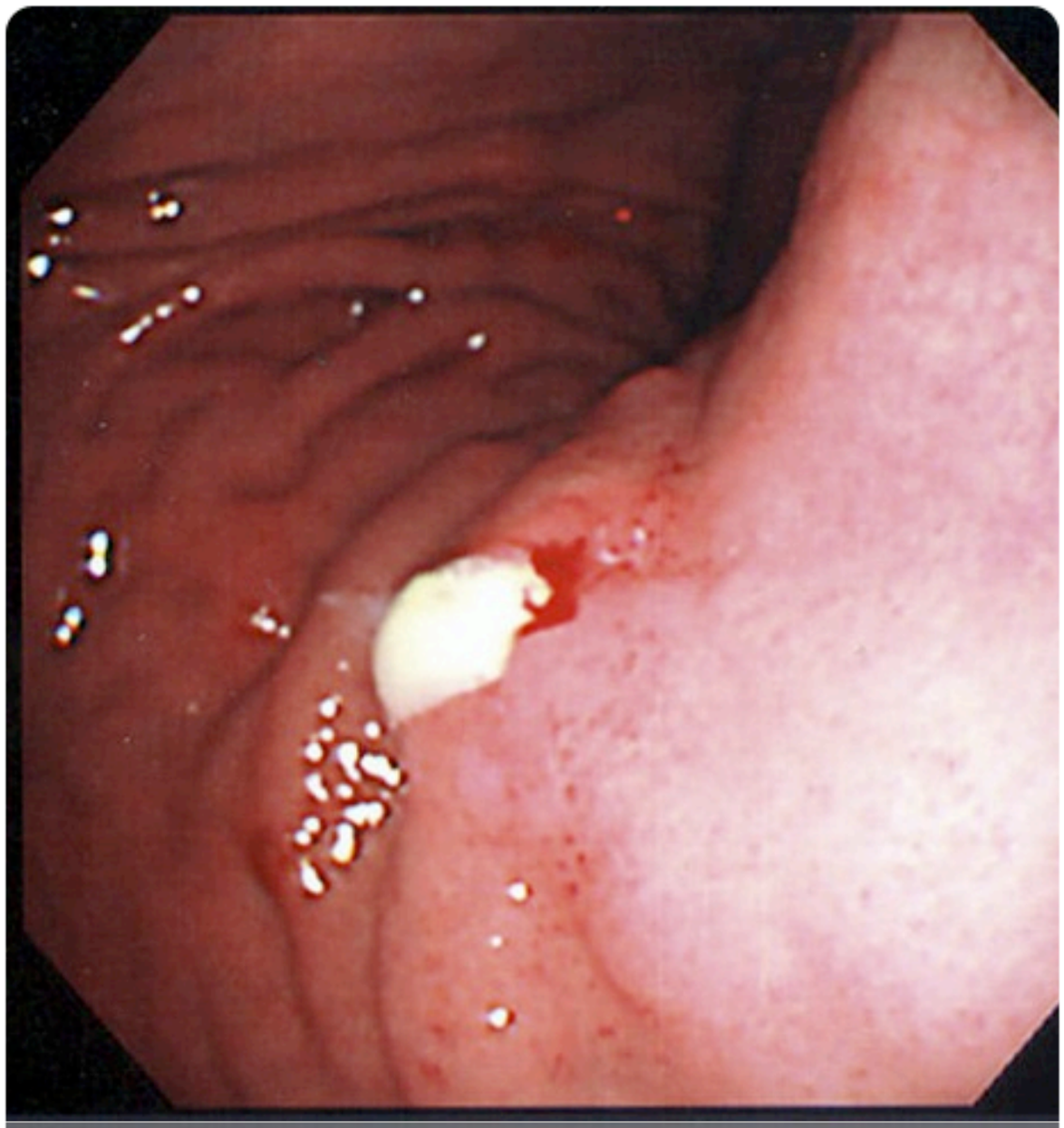
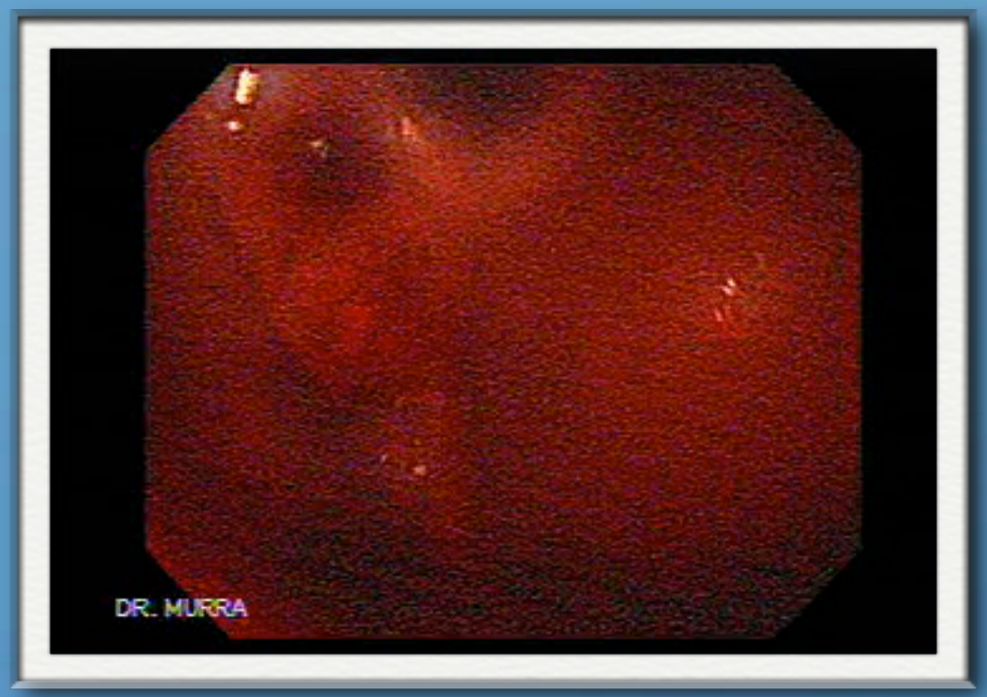
Gastrointestinal haemorrhage



Mr Colin Dibble
Consultant in Emergency Medicine
North Manchester General Hospital

Contents

- Introduction
- Upper GI haemorrhage
  - Differentials
  - Approach
  - Management
- Lower haemorrhage
  - Differentials
  - Approach
  - Management



Introduction

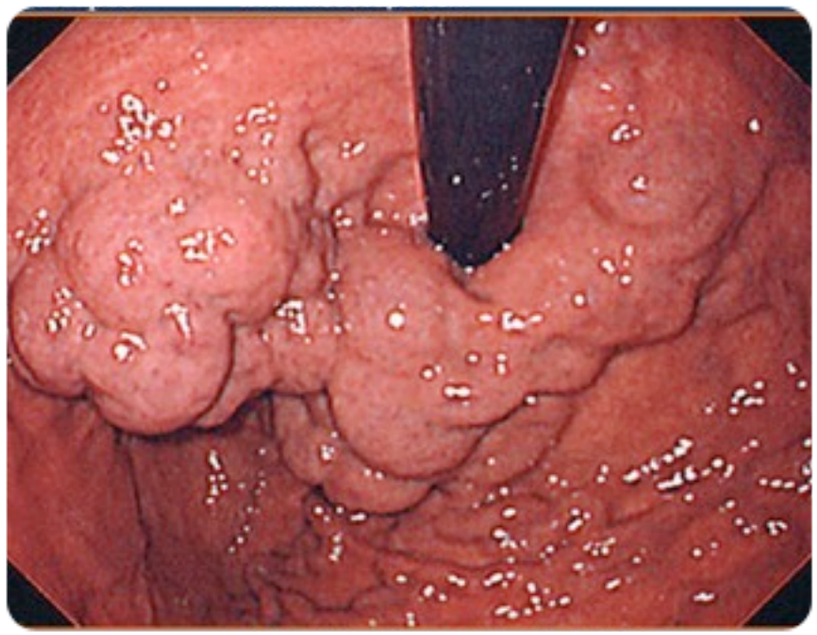
- May be massive, uncontrollable & fatal
- Reasonably common: in NMGH in the last year there was 442 presentations with GI bleed, 313 were admitted
- Mortality increases as age increases up to 25% >70yrs and with coexisting liver/renal/pulmonary disease
- Divided into Upper and Lower GI bleed by the ligament of Treitz. As a general rule, upper GI bleed falls under medics, lower GI bleed falls under surgeons. However, massive upper GI bleeding can result in loss of fresh blood pr

Upper GI bleed

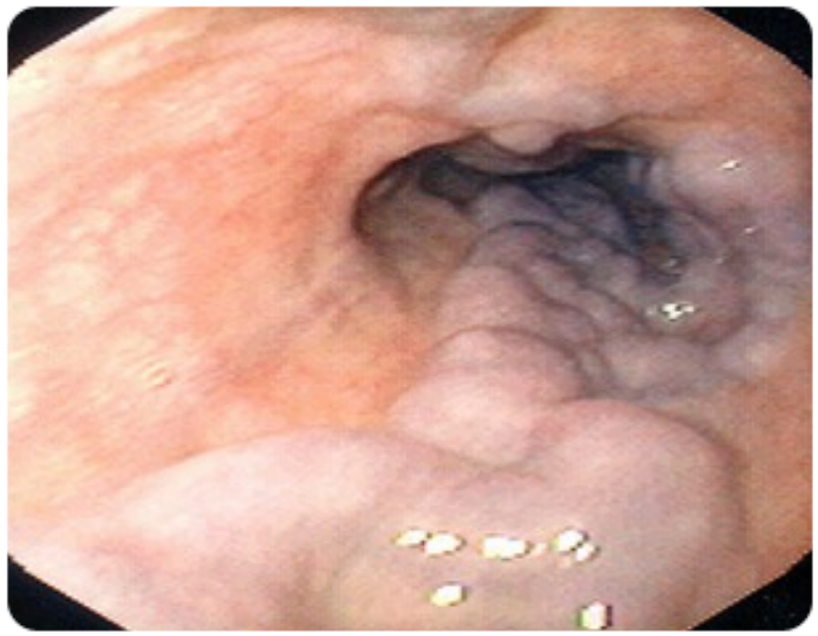
Upper GI bleed

- Causes: (figures form USA)
  - Peptic Ulcer Disease (50%)
  - Oesophageal varices (10-20%)
  - Gastritis (10-25%)
  - Mallory-Weiss Tears (8-10%)
  - Oesophagitis (3-5%)
  - Malignancy (3%)
  - Dieulafoys lesions (1-3%)

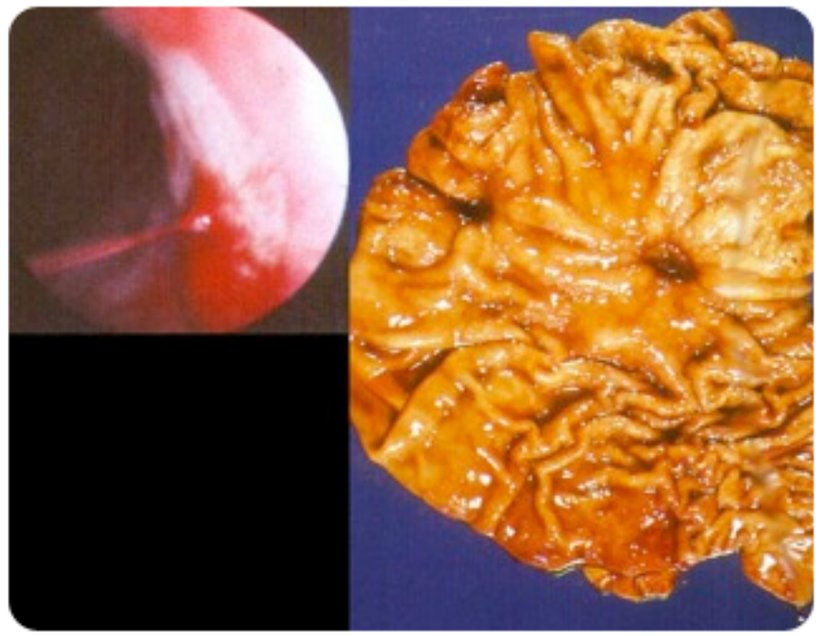
Gastric Varices

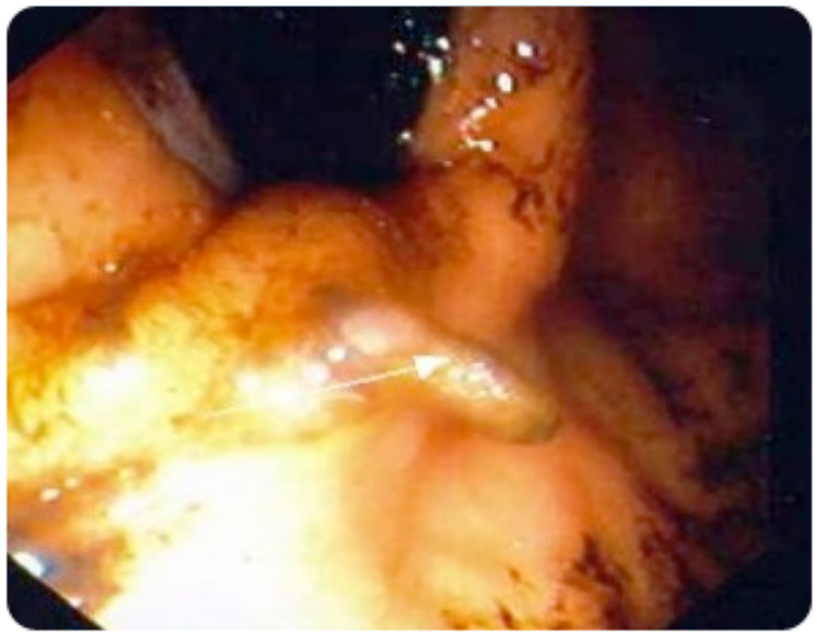


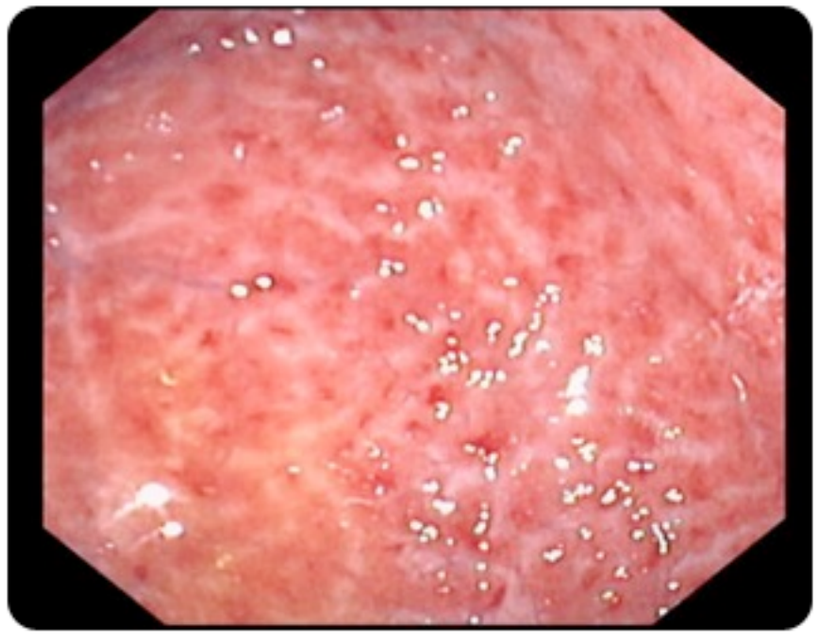
Oesophageal Varices

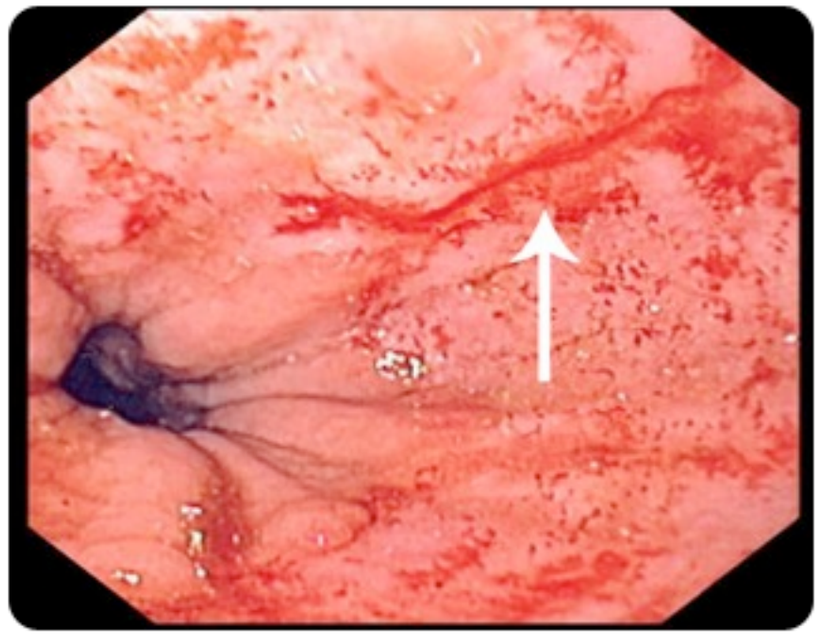


Bleeding ulcers









Deulafoys Lesion

Gastritis

Mallory-Weiss

Upper GI bleed

- Presentation
  - Fatigue, weakness, exertional dyspnoea, orthostatic hypotension
  - Pallor, altered GCS, anxiety
  - Fresh blood/coffee ground vomitus/pr fresh blood
  - Black stools/melaena from haem digestion
  - Occult loss causing iron deficiency anaemia

Upper GI bleed

- History
  - Previous liver disease/cirrhosis/jaundice/alcohol abuse may suggest oesophageal varices
  - Prolonged +/- violent vomiting; Mallory-Weiss tear
  - Previous PUD, abdominal pain; bleeding ulcer
  - Reflux disease/alcohol/NSAIDs; gastritis/oesophagitis
  - Bleeding tendency; on warfarin
- Previous/meds/bowel habits etc

Upper GI bleed

- Examination
  - ABCD, tachycardia, hypotension
  - Signs of chronic liver disease (palmar erythema, flap, spider naevi, jaundice, gynaecomastia, testicular atrophy, oedema etc)
  - Abdominal exam; caput madusae, large spleen, ascites, tenderness

Upper GI bleed

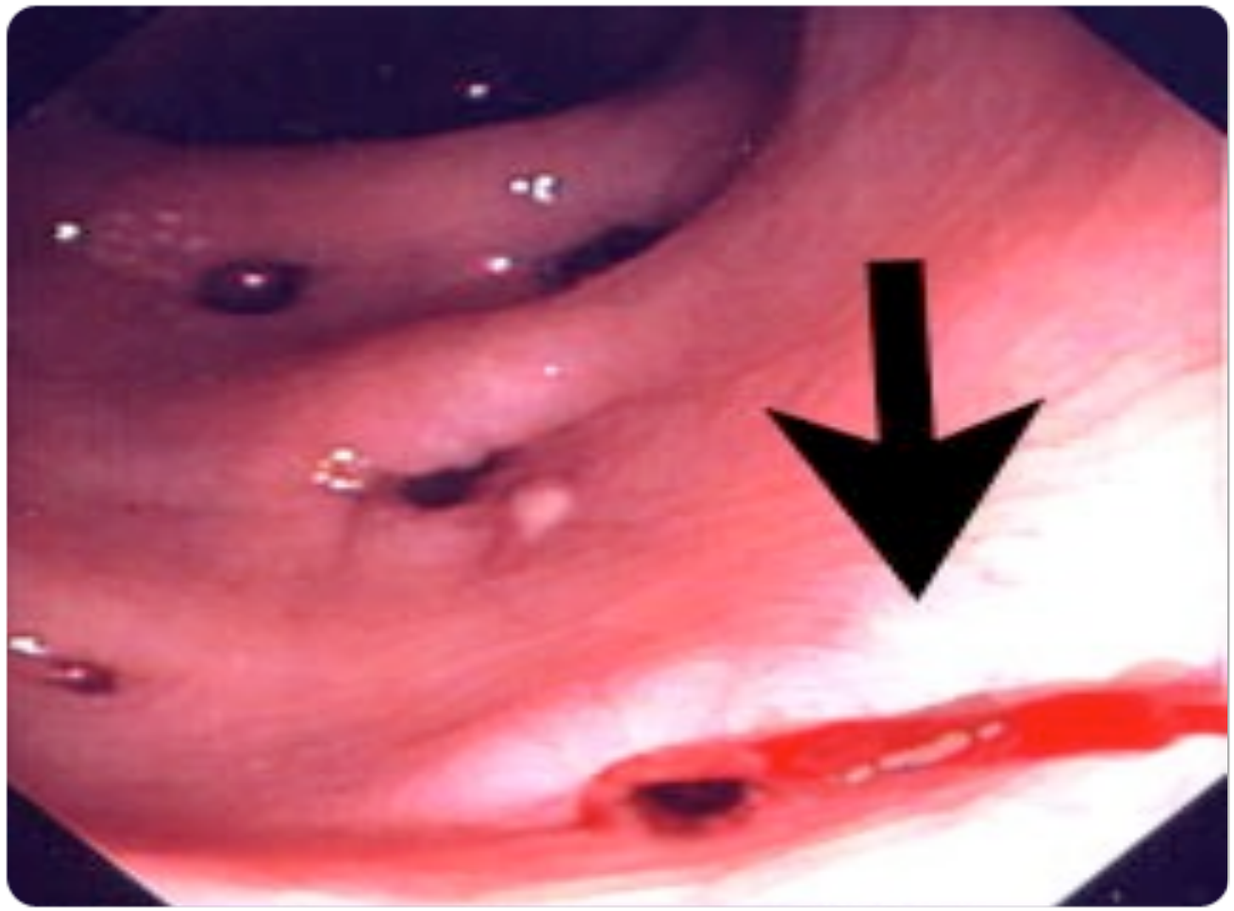
- Management
  - ABCD, O2, 2 large bore cannulae, IV warmed crystalloids to keep sBP>90, cross match 6units, if large haematemesis
  - IV PPI (omeprazole) ONLY at endoscopy if significant bleeding (no evidence for use in A&E)
  - ALL frank haematemesis; refer Medics (will need endoscopy)
  - Involve surgeons and anaesthetists if massive (airway)
  - If only vomitus with blood streaks and no risks for oesophageal varices, may be able to be discharged.
  - Sengstaken-Blakemore tube +/- vassopressin [20u over 15mins]/terlipressin [2mg iv stat] in varices.

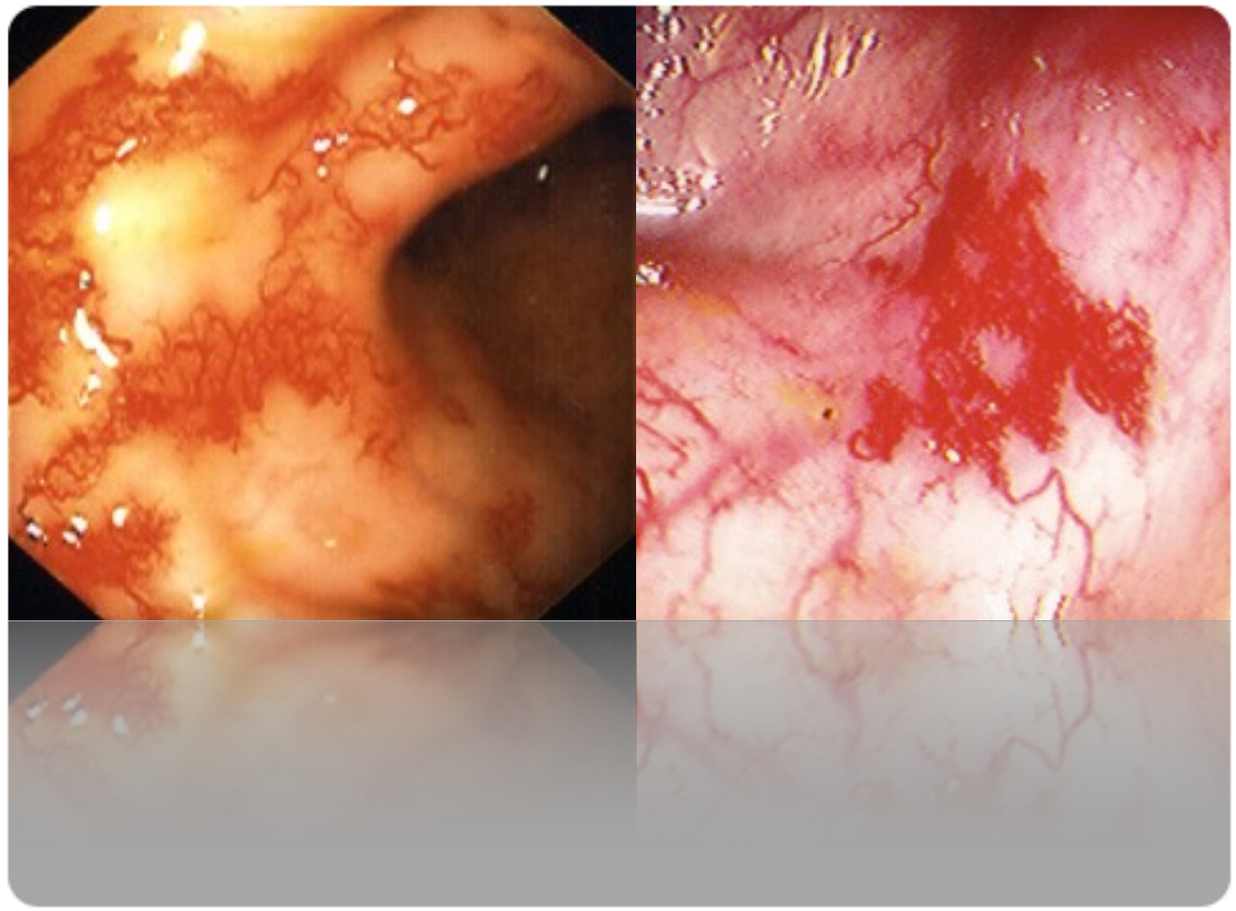
Lower GI Bleeding

Lower GI Bleeding

- Causes (figures form USA):
  - Diverticular disease (40-55%)
  - Angiodysplasia (3-20%)
  - GI polyps
  - Haemorrhoids (2%)
  - Anal fissures
  - Malignancy
  - Trauma
  - Meckels diverticulum (paeds)
  - Intussusception (paeds)

Lower GI Bleeding





Diverticular Disease

Angiodysplasia

Lower GI Bleeding

- Presentation
  - Usually presents with frank bleeding
  - May have anaemia symptoms as above
  - Pain with thrombosed haemorrhoids, fissure
  - Painless with other causes
  - If with diarrhoea ++, inflammatory bowel disease possible
  - Check for LOWt, change in bowel habits etc (malignancy)

Lower GI Bleeding

- Examination
  - As for above
  - Abdominal exam for masses
  - PR exam in all patients, occult blood? May not be possible if fissure as exquisitely painful.

Lower GI Bleeding

- Management
  - ABCD, 2 large bore cannulae and IV warmed crystalloids to keep sBP >90, cross match 6 units
  - Check Hb/Hct/coag etc
  - Refer significant pr bleeding to RSO, (except if clearly inflammatory bowel disease.)
  - If small amount blood and nothing else found, refer back to GP to refer for endoscopy
  - 80% spontaneously resolve

Saturday, 24 January 2009