GI Bleeding Core Content
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- 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 telangectases 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++, Vitamin C (kill the peroxidase)
- Usuals + EKG: silent ischemia
- H/H: Q2Liners, 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