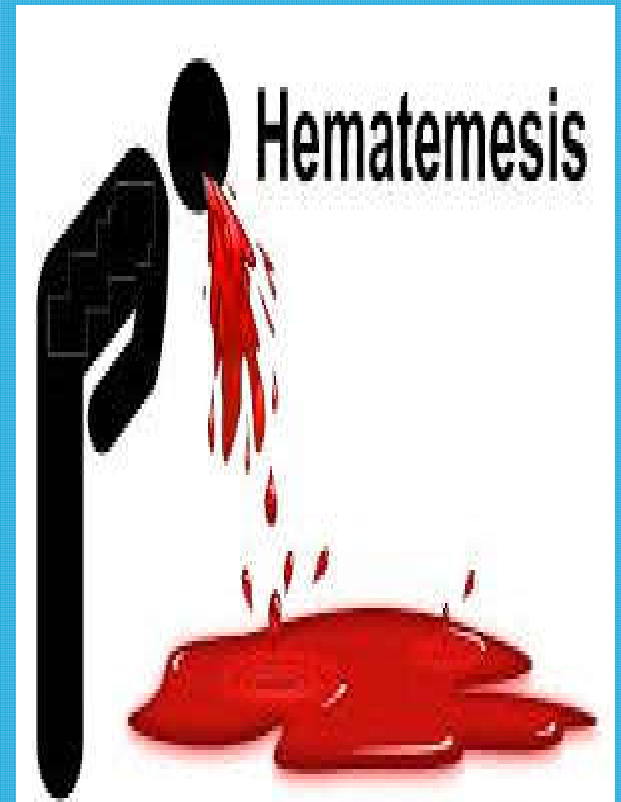




HAEMATEMESIS BY WALAA ABDEL HAMED



HAEMATEMESIS & MELAENA



DEFINITIONS

Haematemesis : vomiting blood due to lesions proximal to ligament of treitz .

Can be categorized as either variceal or non-variceal

May be bright red or coffee-ground .

Should be differentiated from hemoptysis.



TABLE 2

Differentiating Features of Hemoptysis and Hematemesis

Hemoptysis

History

Absence of nausea
and vomiting

Lung disease

Asphyxia possible

Sputum examination

Frothy

Liquid or clotted
appearance

Bright red or pink

Laboratory

Alkaline pH

Mixed with macrophages
and neutrophils

Hematemesis

Presence of nausea
and vomiting

Gastric or hepatic disease

Asphyxia unusual

Rarely frothy

Coffee ground
appearance

Brown to black

Acidic pH

Mixed with food
particles

**Melena : passage of black tarry offensive
soft
stools.**

**Maybe considered upper or lower GIT
bleeding .**



Presentation:

- Haematemesis with or without melaena.
- There may be associated symptoms of lethargy, dizziness, shortness of breath, abdominal or retrosternal pain.
- There may be signs of hypovolaemic shock.



CAUSES

Causes of upper GIT bleeding

A – General causes: e.g. bleeding diathesis

B – GIT causes:

1 - Esophageal causes:

Esophageal varicies - Esophagitis – tumours - trauma.

Rupture aortic aneurysm into esophagus.

2 – Gastroduodinal causes:

Peptic ulcer disease - Gastritis - gastric erosions .

Hiatus hernia - Mallory-Weiss tear.

Tumours - Angiodysplasia.

Hereditary hemorrhagic telangeactasia.

Aorto-enteric fistula.

(Edmundowicz and Zuckerman, 1992)

MANGEMENT

Initial assessment and risk stratification:

- Hemodynamic status should be assessed immediately upon presentation and resuscitative measures begun as needed.
- Blood transfusions should target hemoglobin ≥ 7 g/dl, with higher hemoglobins targeted in patients with clinical evidence of intravascular volume depletion or comorbidities, such as coronary artery disease.
- Risk assessment should be performed to stratify patients into higher and lower risk categories and may assist in initial decisions such as timing of endoscopy, time of discharge, and level of care.



After Stabilization



- Upper gastrointestinal endoscopy should be carried out by an experienced operator as soon as practicable after the patient has been stabilised.
- In patients in whom the bleeding is relatively mild, endoscopy may be carried out on the morning after admission .
- In all cases of severe bleeding it should be carried out immediately.
- A number of scoring systems have been advocated for the assessment of rebleeding and death after upper gastrointestinal .haemorrhage



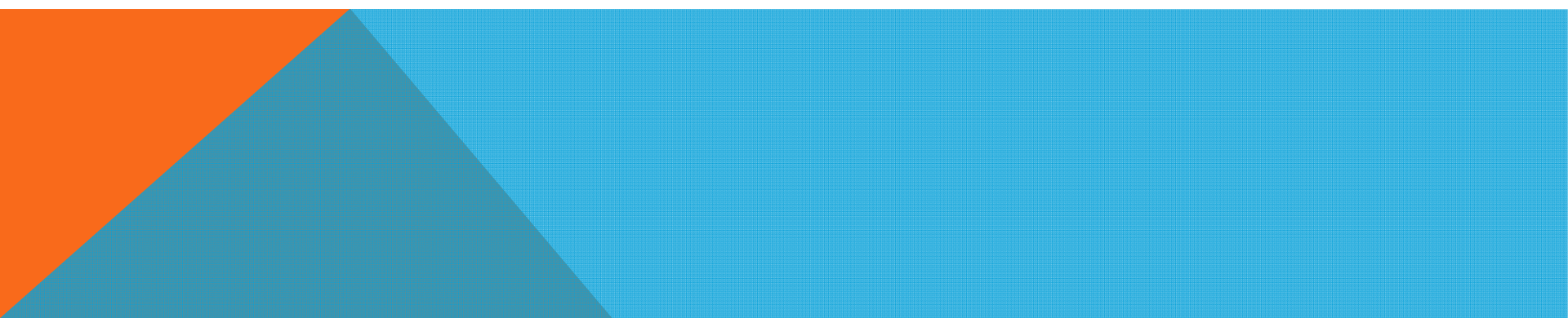
Pre-endoscopic medical therapy

- Intravenous infusion of erythromycin (250 mg ~30 min before endoscopy) should be considered to improve diagnostic yield and decrease the need for repeat endoscopy. However, erythromycin has not consistently been shown to improve clinical outcomes.
- Pre-endoscopic intravenous PPI (e.g., 80 mg bolus followed by 8 mg/h infusion) may be considered to decrease the proportion of patients who have higher risk stigmata of hemorrhage at endoscopy and who receive endoscopic therapy. However, PPIs do not improve clinical outcomes such as further bleeding, surgery, or death.
- If endoscopy will be delayed or cannot be performed, intravenous PPI is recommended to reduce further bleeding.

Vasoactive medications — Somatostatin, its analog octreotide, and terlipressin

are used in the treatment of variceal bleeding and may also reduce the risk of bleeding due to non-variceal causes.

In patients with suspected variceal bleeding, octreotide is given as an intravenous bolus of 20 to 50 mcg, followed by a continuous infusion at a rate of 25 to 50 mcg per hour.



Gastric lavage:

- Nasogastric or orogastric lavage is not required in patients with UGIB for diagnosis, prognosis, visualization, or therapeutic effect .



Timing of endoscopy:

- Patients with UGIB should generally undergo endoscopy within 24 h of admission, following resuscitative efforts to optimize hemodynamic parameters and other medical problems.

- In patients who are hemodynamically stable and without serious comorbidities endoscopy should be performed as soon as possible in a non-emergent setting to identify the substantial proportion of patients with low-risk endoscopic findings who can be safely discharged.



Endoscopic therapy:

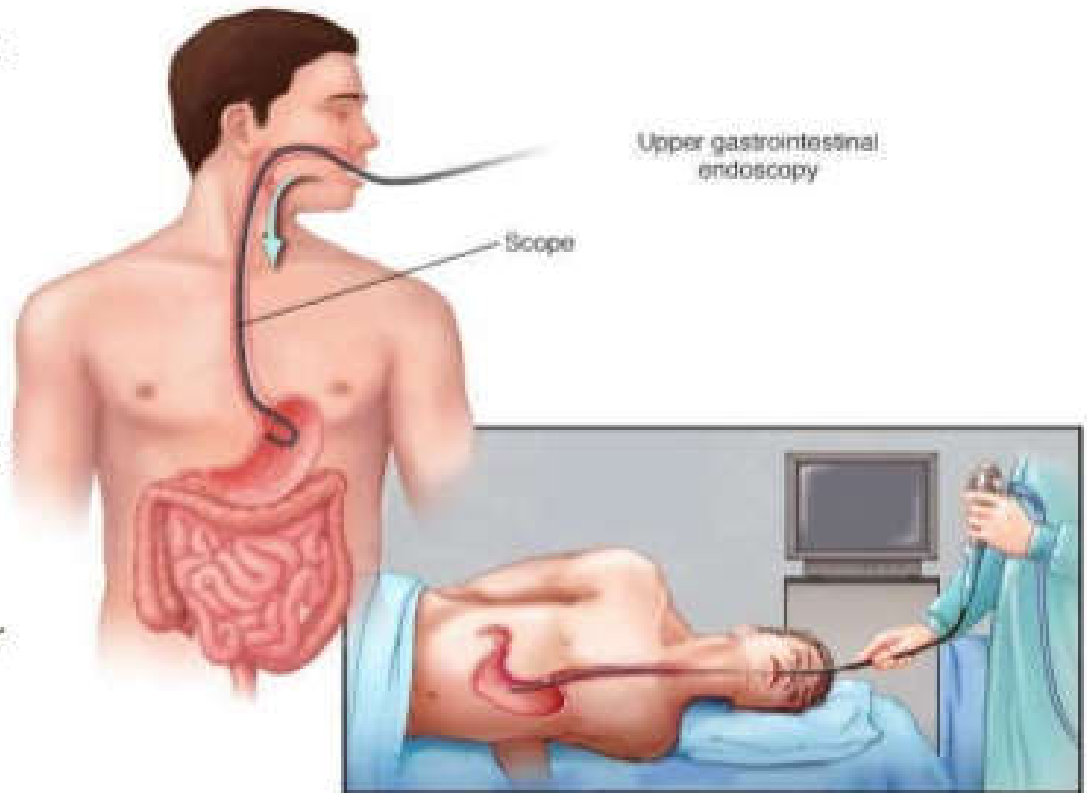
- Endoscopic therapy should be provided to patients with active spurting or oozing bleeding or a non-bleeding visible vessel.
- Endoscopic therapy may be considered for patients with an adherent clot resistant to vigorous irrigation. Benefit may be greater in patients with clinical features potentially associated with a higher risk of rebleeding (e.g., older age, concurrent illness, inpatient at time bleeding began).
- Endoscopic therapy should not be provided to patients who have an ulcer with a clean base or a flat pigmented spot.





- Epinephrine therapy should not be used alone. If used, it should be combined with a second modality.

- Thermal therapy with bipolar electrocoagulation or heater probe and injection of sclerosant (e.g., absolute alcohol) are recommended because they reduce further bleeding, need for surgery, and mortality.



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Medical therapy after endoscopy

- After successful endoscopic hemostasis, intravenous PPI therapy with 80 mg bolus followed by 8 mg/h continuous infusion for 72 h should be given to patients who have an ulcer with active bleeding, a non-bleeding visible vessel, or an adherent clot.
- Patients with ulcers that have flat pigmented spots or clean bases can receive standard PPI therapy (e.g., oral PPI once daily).



Repeat endoscopy

- Routine second-look endoscopy, in which repeat endoscopy is performed 24 h after initial endoscopic hemostatic therapy, is not recommended.
- Repeat endoscopy should be performed in patients with clinical evidence of recurrent bleeding and hemostatic therapy should be applied in those with higher risk stigmata of hemorrhage.
- If further bleeding occurs after a second endoscopic therapeutic session, surgery or interventional radiology with transcatheter arterial embolization is generally employed.

Surgical treatment

- if bleeding persists, or recurs despite endoscopic intervention surgery, should attempted
- factors which should encourage surgical intervention:
 - A large vessel, visible in the ulcer base
 - a major initial bleed,
 - a re-bleed in hospital
 - advanced age
 - Patient who has required more than 6 units

ESOPHOGEAL VARICES



PEPTIC ULCER

