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EMERGENCY MEDICINE BOARD REVIEW MANUAL

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Acute Gastrointestinal Bleeding

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INTRODUCTION

Acute gastrointestinal (GI) bleeding is defined as gross bleeding into the enteric tract. It is a common and potentially life-threatening condition, affecting between 50 and 100 persons per 100,000 in the United States each year. It can occur at all ages but is more prevalent in patients older than 50 years. Upper GI bleeding is more common than lower GI bleeding.

Emergency medicine physicians must be familiar with the current diagnostic modalities and treatment options available for GI bleeding. Hospital stay, morbidity, and number of transfusions can all be minimized by proper initial diagnosis and treatment. The following article discusses the pathophysiology of upper and lower GI bleeds and reviews the diagnosis and treatment of GI bleeding since the advent of improved endoscopy and pharmacotherapy.

APPROACH TO THE PATIENT

TYPICAL PRESENTATION

Patients with GI bleeds reliably present with gross hematemesis, melena, or hematochezia and usually have

evidence of hemodynamic compromise. Hematemesis is gross bloody emesis; it indicates a recent or ongoing GI bleed. Coffee ground emesis contains gross blood that has been coagulated and oxidized by stomach acid and appears as “coffee grounds” floating in stomach aspirate. It usually indicates a significant bleed that has stopped. Melena is tarry black stool produced by gross blood oxidized in the enteric tract with a transit time of more than 8 hours. It may indicate bleeding that occurred up to 3 to 4 days prior. Hematochezia is maroon or bright red gross blood per rectum. It can be present in lower GI bleeding or in upper GI bleeding with rapid transit time.

HISTORY AND PHYSICAL EXAMINATION

When approaching a patient with a complaint of hematemesis or melena, one must first exclude epistaxis, pharyngeal bleeding, or hemoptysis. Once these have been ruled out, a careful history and physical examination should focus on locating the source of the bleeding.

Frequently, a careful history can pinpoint the etiology of the bleeding. Classically, hematemesis or coffee ground emesis suggests upper GI bleeding, and hematochezia indicates lower or distal GI bleeding; however, exceptions do occur. The patient should be questioned about alcohol use because alcohol is strongly associated with a number of causes of GI bleeding, and about drug ingestions, including aspirin, nonsteroidal anti-inflammatory drugs