

The Acute Upper Gastrointestinal Bleed

David W. Nelms, MD^a, Carlos A. Pelaez, MD^{a,b,c,*}

KEYWORDS

- Upper gastrointestinal bleed • Peptic ulcer disease • Variceal bleeding • Endoscopy
- Operative management

KEY POINTS

- Although only 2% to 8% of upper gastrointestinal (GI) bleeds require operative intervention, early surgeon involvement remains imperative.
- Initial evaluation and treatment of upper GI bleeding requires a systematic approach starting with airway, breathing, and circulation.
- Peptic ulcer disease remains the most common cause of upper GI bleeds despite the increased use of proton pump inhibitors and understanding of *Helicobacter pylori*.
- Endoscopy is the main diagnostic and therapeutic tool for most upper GI bleeds.
- Bleeding varices due to portal hypertension can fail medical and endoscopic treatment in 10% to 15% of cases in which transjugular intrahepatic portosystemic shunt may be required. Consideration of facility capabilities and need for transfer should be considered early.

INTRODUCTION

Upper gastrointestinal bleeding (UGIB), defined as intraluminal hemorrhage proximal to the ligament of Treitz, can range from mild and asymptomatic to massive life-threatening hemorrhage.^{1–3} For the purposes of this article, the authors define an acute UGIB to be one that results in new acute symptoms and is, therefore, potentially life-threatening. The incidence of UGIB is approximately 100 cases per 100,000 population per year.⁴ Although the incidence of hospitalization for acute UGIB is decreasing (4% decrease from 1998–2006),⁵ it remains a common problem encountered by the acute-care and general surgeon.

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^a General Surgery Residency Program, UnityPoint Health, 1415 Woodland Avenue, Suite 130, Des Moines, IA 50309, USA; ^b General Surgery, Trauma and Critical Care, The Iowa Clinic, 1212 Pleasant Street, Suite 211, Des Moines, IA 50309, USA; ^c Trauma Services, UnityPoint Health, Iowa Methodist Medical Center, 1200 Pleasant Street, Des Moines, IA 50309, USA

* Corresponding author. Trauma Services, UnityPoint Health, Iowa Methodist Medical Center, 1200 Pleasant Street, Des Moines, IA 50309.

E-mail address: cpelaezgil@iowaclinic.com

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The surgeon continues to play a key role in the outcome of patients with UGIBs. Even though only approximately 2.5% to 5% of UGIBs ultimately require operative intervention,^{1,2} early surgeon consultation remains critical for a variety of reasons. In many practice settings, the surgeon represents the primary endoscopist, but even when this role is assumed by gastroenterology, early surgeon involvement allows for aid in appropriate resuscitation of unstable patients, streamlining of preoperative assessment, early establishment of the goals of the patient and family, and judgment regarding the limits of nonoperative management.

PRESENTATION

UGIB typically presents with hematemesis or melena, but brisk UGIB can present with hematochezia. The redder the blood, the more rapid the bleed. Approximately 80% of all GI bleeds and 11% to 15% of cases of hematochezia are due to an upper source^{6,7}; therefore, it is important to include upper sources in the differential diagnosis for all GI bleeds. Conversely, melena can occur from lower GI bleed that originate in the small bowel or right colon especially when there is slow transit time. Hematemesis almost always represents an upper source of bleeding, although nasal and oropharyngeal sources must also be kept in mind.

TRIAGE

Effective initial evaluation and treatment of an UGIB requires a systematic approach. One organized approach is to divide priorities into a primary survey (airway, breathing, and circulation) and a secondary survey (completion of history and physical examination). The purpose of this division is to emphasize that lack of definitive diagnosis or detailed history and physical examination (H&P) should never impede initiation of airway protection and treatment of shock. Baradaran and colleagues⁸ demonstrated that early intensive resuscitation with correction of hemodynamics, hemoglobin, and coagulopathy can reduce mortality in patients with UGIB. In the massively bleeding patient, it may not be possible to move beyond the primary survey until definitive source control of bleeding has been obtained. However, in most cases, the bleeding stops spontaneously⁹ or the patient is stable enough to allow further details of the H&P to be obtained. Consideration must be given during the primary survey as to whether the health care facility is capable of providing definitive bleeding source control, and arrangements for transfer should be initiated if the facility is unable to care for the patient.

On the opposite extreme, if the patient is found to be stable on the primary survey and the secondary survey does not reveal comorbidities that increase the risk for complications, the patient can potentially be managed as an outpatient. Several clinical decision tools have been created to assist with risk stratification and triage. One is the Glasgow-Blatchford Score (GBS) ([Table 1](#)). This scale is based on clinical parameters that are available before endoscopy. The GBS has been validated and can be used to safely manage patients with a GBS of either 0 or 1 as an outpatient.¹⁰

INITIAL MANAGEMENT (THE PRIMARY SURVEY)

The primary survey is outlined in [Box 1](#). The following key points are emphasized:

1. *Airway and breathing are always the initial priority.*¹¹ Assessment should be performed quickly, and if the airway is compromised a definitive airway is required. Ongoing reassessment of the airway must be performed. Mental status changes due to shock may lead to patient inability to protect their own airway. Pragmatic

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