

Gastrointestinal Bleeding and Management



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KEYWORDS

- Hematemesis • Hematochezia • Melena • Peptic ulcer • Varices
- Vascular anomaly • Endoscopy

KEY POINTS

- There is a broad clinical spectrum of gastrointestinal hemorrhage.
- Obtaining an accurate history and conducting a thorough physical examination can provide important clues about the location, severity, and likely etiology of gastrointestinal bleeding.
- There are blood tests, radiologic tools, and endoscopic methods to identify a bleeding source.
- Early consultation with a gastroenterologist is recommended, as endoscopy is often required for evaluation and may be needed to control hemorrhage.

INTRODUCTION

The presentation of gastrointestinal bleeding in children can vary from subtle findings of pallor and iron-deficiency anemia to obvious episodes of vomiting frank blood. Children present with this chief complaint in a variety of clinical settings, but there is a paucity of literature capturing the epidemiology of pediatric gastrointestinal hemorrhage. Gastrointestinal bleeding can manifest in several ways. Hematemesis is the expulsion of bright red or “coffee-ground” colored material from the mouth. This usually indicates bleeding proximal to the Ligament of Treitz, as fresh red blood exposed to an acidic environment turns brown.¹ Melena typically correlates with an esophageal, gastric, or proximal small intestinal bleeding source and leads to passage of black, tarry stool per rectum. This appearance can be attributed to oxidization by intestinal bacteria that convert hemoglobin to hematin.² In contrast, hematochezia is bright red or maroon-colored material that passes from the rectum. Although

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hematochezia most often occurs with lower small intestinal or colonic bleeding sources, a brisk upper gastrointestinal bleed may present as bright red blood per rectum, with blood in the intestinal lumen acting as a cathartic agent and accelerating transit. Obscure gastrointestinal bleeding is blood loss that is not identified by upper endoscopy, colonoscopy, and radiologic evaluation of the small intestine.³ It can be further classified into obscure overt and obscure occult bleeding, based on extent of clinically obvious bleeding.⁴ There are many exhaustive reviews of etiologies of pediatric gastrointestinal bleeding.^{1,2,5-9} Our goal is to provide a framework for evaluation of patients with gastrointestinal bleeding and to review management principles.

DISCUSSION

Historical Report

A careful history may shed light on the source of bleeding and rate of blood loss. It is important to inquire about the color, quantity, and location of bleeding. The temporal association of the bleeding episode to other signs and symptoms, including abdominal pain, vomiting, and fevers should be characterized. Eliciting this history in an emergency scenario with distraught patients or unwitnessed events can be challenging. For instance, hemoptysis can be mistaken for hematemesis.¹⁰ However, unveiling key historical details may provide critical clues to localize the bleeding source. A history of recent tonsillectomy, dental procedure, epistaxis, or nasogastric tube placement may indicate nasopharyngeal or oropharyngeal bleeding. An underlying anxiety disorder may be accompanied by chronic cheek chewing (morsicatio buccarum) with bleeding from the mouth or vomiting swallowed blood. Ingestion of a button battery or sharp foreign body may cause mucosal tears, ulcerations, or even life-threatening aortoenteric fistulae.¹¹ Discovery of prior intestinal operation could heighten concern for a bleeding ulcer from a surgical anastomosis ([Fig. 1](#)). A thorough medication history may reveal use of aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs) that could increase bleeding risk. Many substances can give the false

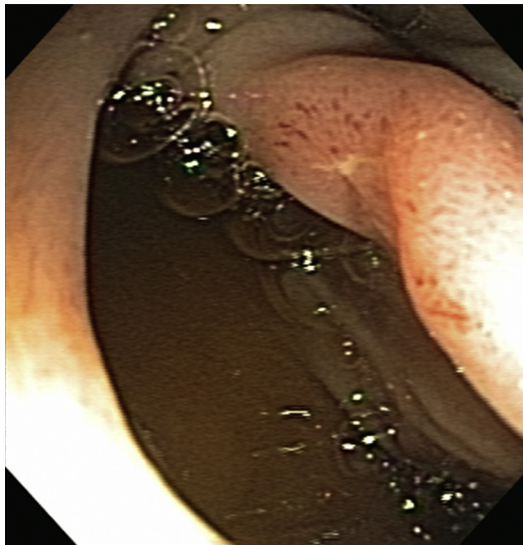


Fig. 1. Ulcer at jejunocolonic anastomosis in young girl with a history of jejunal atresia and multiple bowel resections as a neonate.

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