Bleeding from right colonic vascular ectasias in the elderly may be overt or occult; it tends to be chronic and only occasionally is hemodynamically significant. Endoscopic hemostatic therapy may be useful in the treatment of vascular ectasias, as well as discrete bleeding ulcers and postpolypectomy bleeding. Surgical therapy is generally required for major, persistent, or recurrent bleeding from the wide variety of colonic sources of GIB that cannot be treated medically, angiographically, or endoscopically.

APPROACH TO THE PATIENT: Gastrointestinal Bleeding

INITIAL ASSESSMENT

Measurement of the heart rate and blood pressure is the best way to initially assess a patient with GIB. Clinically significant bleeding leads to postural changes in heart rate or blood pressure, tachycardia, and, finally, recumbent hypotension. In contrast, the hemoglobin does not fall immediately with acute GIB, due to proportionate reductions in plasma and red cell volumes (i.e., "people bleed whole blood"). Thus, hemoglobin may be normal or only minimally decreased at the initial presentation of a severe bleeding episode. As extravascular fluid enters the vascular space to restore volume, the hemoglobin falls, but this process may take up to 72 h. Transfusion is recommended when the hemoglobin drops below 7 g/dL, based on a large randomized trial showing this restrictive transfusion strategy decreases rebleeding and death in acute UGIB compared with a transfusion threshold of 9 g/dL. Patients with slow, chronic GIB may have very low hemoglobin values despite normal blood pressure and heart rate. With the development of iron-deficiency anemia, the mean corpuscular volume will be low and red blood cell distribution width will increase.

DIFFERENTIATION OF UGIB FROM LGIB

Hematemesis indicates an upper GI source of bleeding (above the ligament of Treitz). Melena indicates blood has been present in the GI tract for at least 14 h, and as long as 3–5 days. The more proximal the bleeding site, the more likely melena will occur. Hematochezia usually represents a lower GI source of bleeding, although an upper GI lesion may bleed so briskly that blood transits the bowel before melena develops. When hematochezia is the presenting symptom of UGIB, it is associated with hemodynamic instability and dropping hemoglobin. Bleeding lesions of the small bowel may present as melena or hematochezia. Other clues to UGIB include hyperactive bowel sounds and an elevated blood urea nitrogen (due to volume depletion and blood proteins absorbed in the small intestine).

A nonbloody nasogastric aspirate may be seen in up to ~18% of patients with UGIB, usually from a duodenal source. Even a bile-stained appearance does not exclude a bleeding postpyloric lesion because reports of bile in the aspirate are incorrect in ~50% of cases. Testing of aspirates that are not grossly bloody for occult blood is not useful.

EVALUATION AND MANAGEMENT OF UGIB (FIG. 57-1)

At presentation, patients are generally stratified as higher or lower risk for further bleeding and death. Baseline characteristics predictive of rebleeding and death include hemodynamic compromise (tachycardia or hypotension), increasing age, and comorbidities. PPI infusion may be considered at presentation: it decreases high-risk ulcer stigmata (e.g., active bleeding) and need for endoscopic therapy but does not improve clinical outcomes such as further bleeding, surgery, or death. Treatment to improve endoscopic visualization with the promotility agent erythromycin, 250 mg intravenously ~30 min before endoscopy, also may be considered: it provides a small but significant increase in diagnostic yield and decrease in second endoscopies but is not documented to decrease further bleeding or death. Cirrhotic patients presenting with UGIB should be placed on antibiotics (e.g., quinolone, ceftriaxone) and started on a vasoactive medication (octreotide, terlipressin, somatostatin, vapreotide) upon presentation, even before endoscopy. Antibiotics decrease bacterial infections, rebleeding, and mortality in this population, and vasoactive medications appear to improve control of bleeding in the first 12 h after presentation.

Upper endoscopy should be performed within 24 h in most patients with UGIB. Patients at higher risk (e.g., hemodynamic instability, cirrhosis) may benefit from more urgent endoscopy within 12 h. Early endoscopy is also beneficial in low-risk patients for management decisions. Patients with major bleeding and high-risk endoscopic findings (e.g., varices, ulcers with active bleeding or a visible vessel) benefit from endoscopic hemostatic therapy, whereas patients with low-risk lesions (e.g., clean-based ulcers, nonbleeding Mallory-Weiss tears, erosive or hemorrhagic gastropathy) who have stable vital signs and hemoglobin and no other medical problems can be discharged home.

EVALUATION AND MANAGEMENT OF LGIB (FIG. 57-2)

Patients with hematochezia and hemodynamic instability should have upper endoscopy to rule out an upper GI source before evaluation of the lower GI tract.

Colonoscopy after an oral lavage solution is the procedure of choice in most patients admitted with LGIB unless bleeding is too massive,

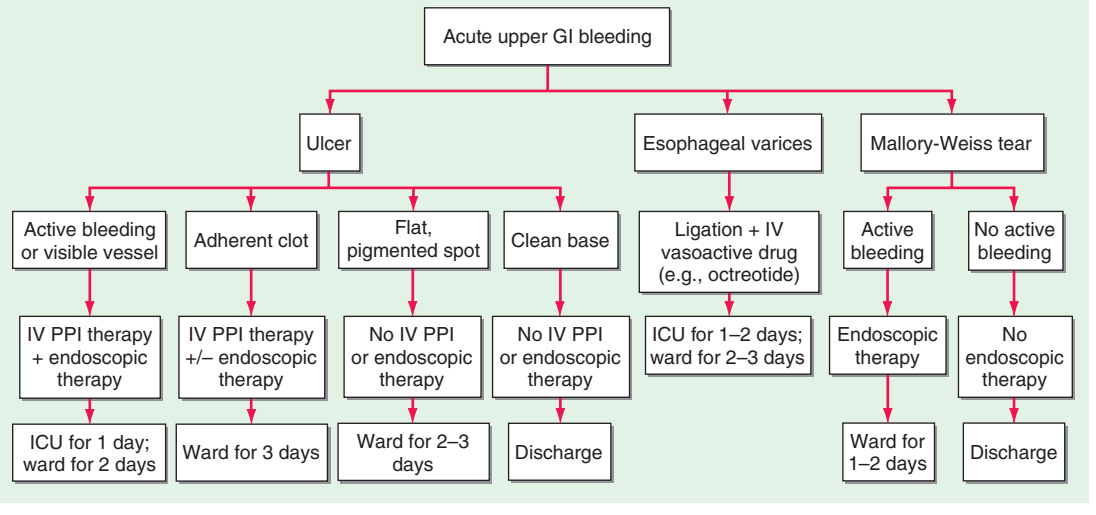

FIGURE 57-1 Suggested algorithm for patients with acute upper gastrointestinal (GI) bleeding. Recommendations on level of care and time of discharge assume patient is stabilized without further bleeding or other concomitant medical problems. ICU, intensive care unit; PPI, proton pump inhibitor.