MANAGEMENT OF LOWER G.I.T. BLEEDING

ESSAY

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By

TAREK SALEM EL-MENOUFY

(M.B., B.Ch.)

Under Supervision of

PROFESSOR DR. HAMDY MAHMOUD ABDALLA

Professor of General Surgery

Faculty of Medicine, Ain Shams University

DR. AHMED ABDEL AZIZ ABOUZEID

Lecturer of General Surgery

Faculty of Medicine, Ain Shams University

Faculty of Medicine

Ain Shams University

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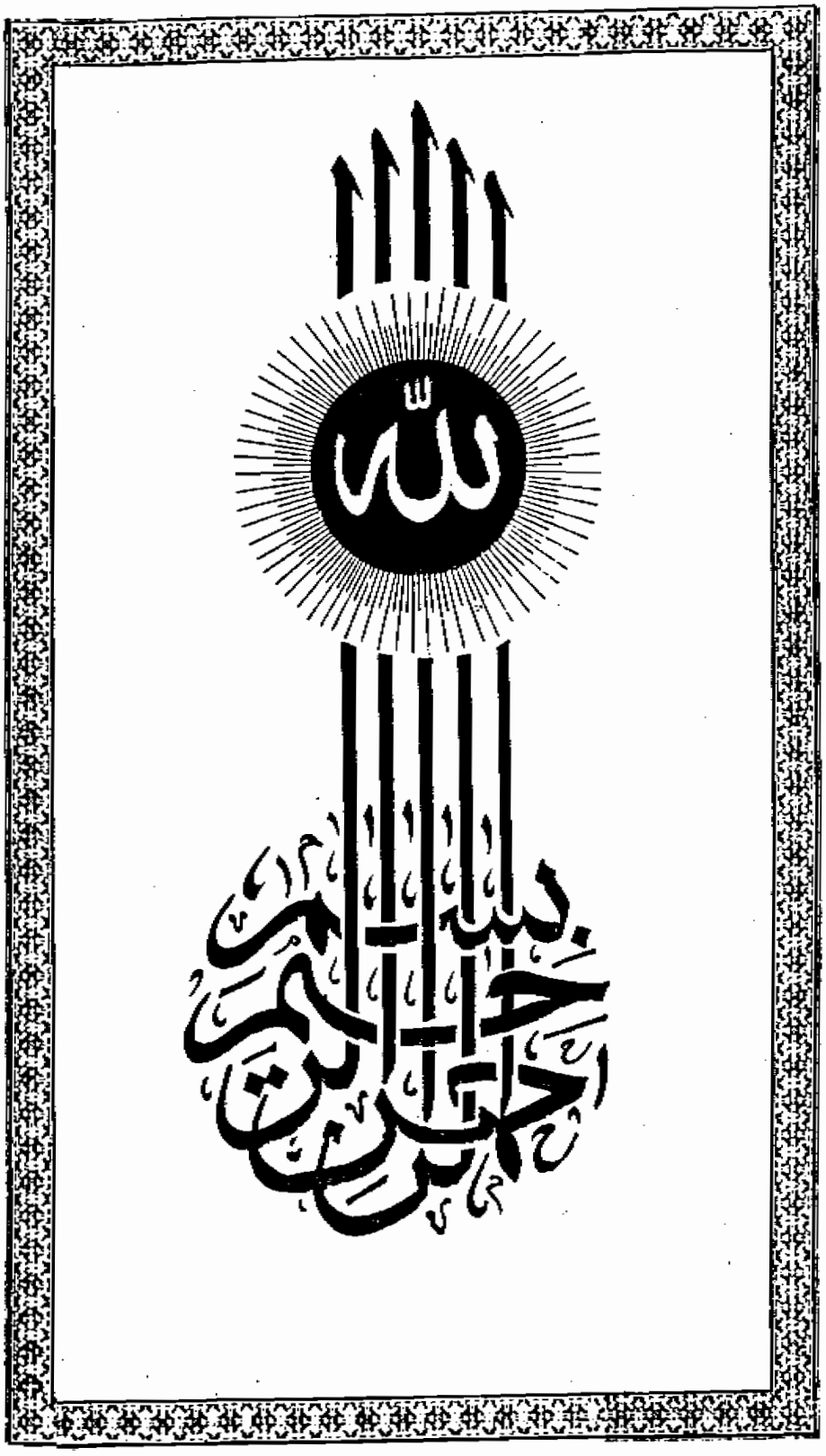
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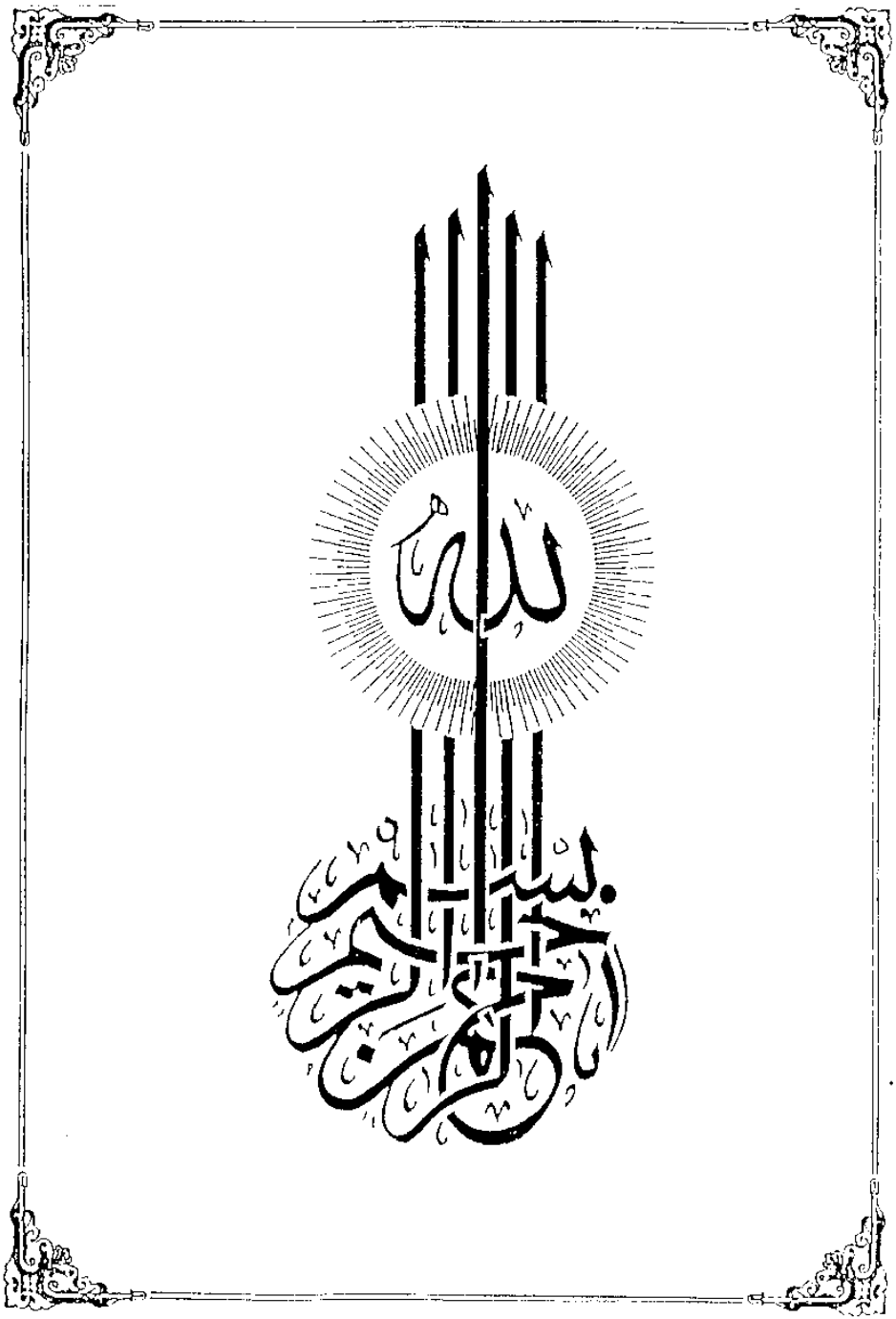

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ABSTRACT

Lower G.I.T. bleeding may prove to be a clinical and diagnostic challenge. 90% of patients stop bleeding spontaneously. Patients with massive bleeding should undergo arteriography as soon as possible. For those requiring surgery segmental resection of bleeding site should be performed. If the clinician is unsure of diagnosis, subtotal colectomy should be under taken.

INTRODUCTION AND HISTORICAL REVIEW OF LOWER G.I.T. BLEEDINGS

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Lower G.I.T. bleeding is one of the commonest and most important presenting symptom in the surgical department either as acute urgent cases in the emergency room or chronic cold cases in outpatient clinic.

Bleeding per rectum means passage of blood via the rectum and anal canal with or without stool. It may be bright red or dark red jelly like and usually it indicates bleeding from lower G.I.T.

The diagnosis of the underlying cause and site of lower G.I.T. bleeding is often most challenging. Current methods of localization of the origin of bleeding are far from being satisfactory. The surgeon is often left in a dilemma as to which part of the lower G.I.T. he should tackle.

The bleeding may be massive and in such case, the patient presents with evidence of circulatory embarrassment, this threat is evident. However, even a relatively small bleeding episode may present a later massive haemorrhage alternatively even mild bleeding which is not itself a threat to patient's life may be the presenting symptom or a sign of a major illness

such as carcinoma of the caecum. Yet again a massive bleeding episode may complicate a relatively benign condition such as peptic ulcer. Also a patient with known history of a certain disease such as peptic ulcer may come with rectal bleeding of another different source. Again a possible apparent cause of bleeding, e.g., piles may be in itself the presentation of a hidden more serious lesion such as malignancy.

The recent use of selective and superselective mesenteric arteriography, fibreoptic scopes and radionuclide isotopes, during actual bleeding in cases of massive rapid haemorrhage, has been most revealing. It has been shown that bleeding can originate in areas of diverticular disease, from other lesions, e.g., carcinoma of colon, polyps, haemorrhoids, vascular abnormalities of the colonic wall, inflammatory bowel disease such as ulcerative colitis, and Crohn's disease. Less common causes are late complications of pelvic irradiation intestinal varices in portal hypertension and caecal ulcer complicating cytomegalo-virus infection in transplant patient.

The cause of lower G.I.T. bleeding have been continually changing during the past fifty years. In the 1920's neoplasms were considered the most frequent cause of significant bleeding; bleeding from diverticular disease was thought to be rare (Lockhart and Mummery, 1923). However, by the late 1940's and early 1950's haemorrhage attributed to diverticular disease

In this essay the different opinions in lower G.I.T. bleeding problem will be discussed. At first the possible aetiological factors will be discussed and their pathological nature and clinical presentation especially of those the major common causes will be discussed in short in order to reach the provisional diagnosis which is necessary for primary management and further investigations needed, the different methods of investigations needed for proper diagnosis will be discussed also, lastly the therapeutic means and surgical management of the different causes for both acute urgent cases and chronic cold cases will be mentioned and at the end a precise summary is given.

AETIOLOGY AND PATHOGENESIS OF LOWER G.I.T. BLEEDING

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Acute lower G.I.T. bleeding is usually manifested by passage of bright red or dark blood per rectum. In vast majority of patients, this clinical sign means that the source of bleeding is located in the rectum, colon or distal small intestine. However, massive bleeding from oesophagus, stomach or proximal small intestine may present with bright red blood per rectum (haomatochezia). The presence of hypotension or postural changes in the pulse rate and the blood pressure help to define those patients with massive bleeding from the upper G.I.T. The majority of patients with acute lower G.I.T. bleeding do not bleed massively and therefore infrequently have postural blood pressure and pulse changes and only rarely do they require blood transfusion for stabilization. Exception to this general rule may be the massive bleeding in patients with right-sided colonic diverticula and/or colonic vascular ectasia (Tedesco and Waye, 1980).

In all patients with occult blood loss, causes in the upper G.I.T. should be excluded by oesophago-gastro-duodenoscopy and if this does not reveal the cause, by barium meal and follow-through examination (Hunt, 1978).

The patient with rectal bleeding, may be suffering from simple complaint such as haemorrhoids or anal fissure, but the differential diagnosis includes more serious diseases, some of which are listed in Table (1) (Hunt, 1978).

TABLE (1)

Causes of Rectal Bleeding

. Haemorrhoids
. Anal fissure
. Colonic polyps
. Diverticular disease
. Inflammatory bowel disease: u/C - Crohn's disease
. Infective-amoebic colitis, etc.....
. Ischaemic and radiation colitis
. Solitary ulcer of the rectum.
. Vascular abnormatities-angioma/angiodysplosia
. Rectal varices
. Causes above the ileo Cecal Value: Meckel's diverticuum.
. Causes in the upper G.I.T.: bleeding peptic ulcer.

(Welch et al., 1978)

Noer et al. (1962) is an analysis of the causes of gross rectal bleeding in 245 cases, admitted to hospital under their care with this complaint, divided the patients to two groups according to whether the bleeding was moderate or severe (Tables 2, 3).

However, diverticular disease was easily listed as the most common cause of massive bleeding (Goligher, 1980).

TABLE (2)

Causes of mild to moderate Rectal Bleeding in 221 Patients under care of Noer and his Colleagues

Causes	No. of Cases
. Carcinoma of left colon	73
. Diverticutitis	61
. Diverticulosis	45
. Ulcerative Colitis	39
. Polyps	23
. Carcinoma of right colon	13
. Miscellaneous	12

(After Noer et al., 1962)