سامية محمد مصطفى

شبكة المعلومات الجامعية

بسم الله الرحمن الرحيم

سامية محمد مصطفى

شبكة المعلومات الجامعية

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التوثيق الالكتروني والميكروفيلم

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سامية محمد مصطفى

جامعة عين شمس

التوثيق الإلكتروني والميكروفيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها علي هذه الأقراص المدمجة قد أعدت دون أية تغيرات

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سامية محمد مصطفى

شبكة المعلومات الجامعية

بالرسالة صفحات لم ترد بالأصل

LOWER GASTROINTESTINAL BLEEDING

ESSAY
SUBMITTED FOR PARTIAL FULFILMENT FOR
M. Sc. IN GENERAL SURGERY

BY

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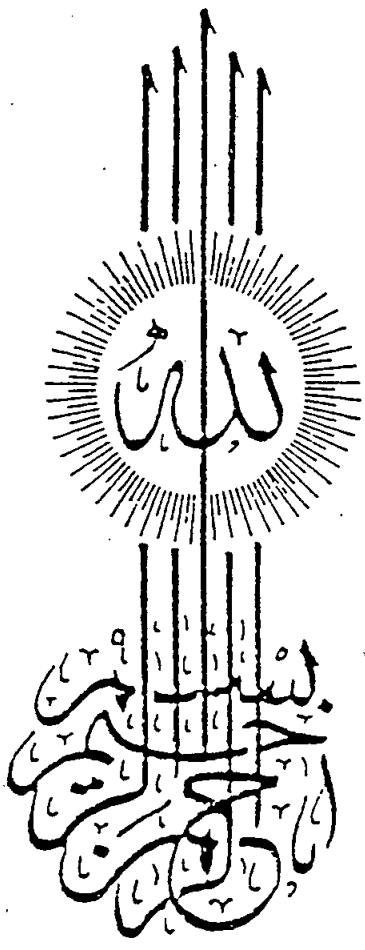

﴿ وعلمك ما لم تكن تعلم
وكان فضل الله عليك عظيما ﴾

صدق الله العظيم [النساء ١١٣]

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INTRODUCTION & AIM OF THE ESSAY

Lower gastrointestinal tract haemorrhage is one of the commonest and most important presenting symptoms in the surgical department either in outpatient clinic or in the emergency room. Lower gastrointestinal haemorrhage is a haemorrhage which arises from beyond the range of an upper endoscope , i.e mid of 2nd part of duodenum **[Ambrose et al., 1983].**

Bleeding per rectum is defined as passage of blood through the rectum and anus. This blood may be occult or overt, acute massive or chronic loss of small amounts over long period. Melena is the passage of dark red blood per rectum, upper gastrointestinal bleeding can be severe enough to cause bleeding per rectum rather than melaena **[Mortenson and Kettlewell., 1996].**

Haematochezia is the passage of gross blood in the stool, may indicate bleeding in both upper and lower tracts. In fact, melena rather than haematemesis is usually the presenting sign of upper tract bleeding. Haematochezia may also indicate brisk bleeding from the upper tract, when the transit time of gasrointestinal contents is short and may not allow the blood to be digested **[Walter and Tunnessen., 1988].**

The amount of blood passed, age of the patient, associated symptoms and condition of the patient and location of the blood in the stool are important diagnostic considerations. In

the past, gastrointestinal bleeding went unexplained in as many as half the cases; at present, with more precise tools such as fiberoptic endoscopy, a definitive diagnosis should be possible more often **[Walter and Tunnessen.,1988].**

Occult gastrointestinal bleeding may present as a positive guaiac test on one or more stool specimens (without melena or haematochasia) or as iron deficiency anemia with or without a guaiac-positive stool. Occult gastrointestinal bleeding can be found in patients who may or may not have gastrointestinal symptoms or in a symptomatic subjects, being mass-screened for colon cancer. The potential bleeding sites includes the upper gastrointestinal tract, colon, rectum and the small bowel **[Zuckerman and Benitez.,1992].**

The commonest source of the bleeding is the colon , accounting 85% of cases . The upper gastrointestinal tract account for 10% and the small intestine 5%. The commonest causes of massive lower gastrointestinal bleeding are, diverticular disease and angiodysplasia, however, there are a wide variety of gastrointestinal lesions that can cause rectal bleeding , including upper gastrointestinal lesions. 75% of colonic bleeding usually stops spontaneously **[Goligher, 1984].**

Aim of the essay

The aim of this essay is to highlight the problem of lower gastrointestinal bleeding, go through the recent advances and define a plan for its management.

Review Of Literature

Surgical Anatomy Of Lower Gastrointestinal Tract

SURGICAL ANATOMY

Anatomy of the small intestine:-

The small intestine in an adult is 5-6m long from the ligament of Treitz to the ileocecal valve. The upper two fifths of the small intestine distal to the duodenum are termed the jejunum and the lower three fifths the ileum. There is no sharp demarcation between the jejunum and the ileum; however, as the intestine proceeds distally, the lumen narrows, the mesenteric vascular arcades became more complex, and the circular mucosal folds became shorter and fewer. In general, the jejunum resides in the left side of the peritoneal cavity, and the ileum occupies the pelvis and right lower quadrant **[Schrock, 1994].**

The suspensory muscle of the duodenum [ligament of Treitz]: is a fibromuscular band arising from the right crus of the diaphragm and inserting at the upper surface of the duodeno-jejunal flexure. It passes posterior to the pancreas and the splenic veins and anterior to the left renal vein. Its course superiorly is close to the coeliac artery **[Gray and Skandalakis, 1972].**

The small bowel is attached to the posterior abdominal wall by the mesentery, a reflection from the posterior parietal peritoneum. This peritoneal fold arises along a line originating just to the left of the midline and passing obliquely to the right lower quadrant. Although the mesentery joins the intestine along one side, the peritoneal layer of the mesentery envelops the bowel and is called the visceral peritoneum, or serosa **[Schrock, 1994].**

Blood supply of the small intestine:-

*** Arterial supply:**

The superior mesenteric artery arises from the aorta below the origin of the coeliac trunk. In about one percent of