Lower Gastrointestinal Bleeding

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INTRODUCTION

Lower gastrointestinal bleeding (LGIB) is defined as any bleeding that originates distal to the ligament of Treitz. The incidence of LGIB in the United States is 20 to 27 cases per 100,000 persons per year. It occurs more commonly in men than women and with increasing frequency among the elderly. There is a 200-fold increase in risk of LGIB from the third decade to the ninth decade of life. Furthermore, patients increasingly are being treated with long-term anticoagulation/antiplatelet therapy, which can increase a patient’s risk of developing LGIB by 22%.

The patient’s description of the amount of hemorrhage can be misleading, since it takes only a small amount of blood in the commode to discolor the water. Patients can have small amounts of blood mixed with mucous or stool, or they can experience large amounts of brisk bleeding. The history does not accurately predict the outcome of the bleeding. Some patients will stop bleeding after their first episode, while others will continue bleeding, leading to significant blood loss. For most patients, however, the bleeding will resolve spontaneously with only supportive care, and in the majority of cases, the actual site of bleeding will never be localized.

It is important to understand as a clinician that as many as 10% to 15% of patients with LGIB symptoms will have an upper gastrointestinal source of bleeding. The difficulty with management of LGIB is that bleeding can occur at any site throughout the gastrointestinal tract and may commonly be intermittent. If managed inappropriately, a patient may undergo surgery without localization of the bleeding source and after resection continue to bleed.

EVALUATION AND DIAGNOSIS

CASE PATIENT 1

A 57-year-old man with a history of hypertension and hyperlipidemia presents for evaluation following 3 episodes of passing bright red blood from his rectum. The last episode occurred about 20 minutes prior to presentation, with several “cups” of bright red blood being expelled. He occasionally takes an aspirin and has never had a colonoscopy or experienced similar symptoms. He has associated lightheadedness and dizziness on standing. His blood pressure is 90/62 mm Hg and his pulse is 92 bpm in the supine position. His blood pressure decreases to 72/48 mm Hg and his heart rate increases to 118 bpm upon sitting up. His hypertension is managed using an angiotensin-converting enzyme inhibitor. He denies any use of nonsteroidal anti-inflammatory medications (NSAIDs). The remainder of his history and physical examination is unremarkable.

• What should be the first steps in the management of this patient?

Initial Management

The ABCs of resuscitation (airway, breathing, circulation) should be the first steps in managing any patient who is actively hemorrhaging. Two large-bore intravenous lines should be placed, and vital signs should be monitored frequently along with orthostatic blood pressures. Foley catheter placement is encouraged to ensure adequate urine output. Laboratory evaluation should include a hemoglobin and hematocrit, type and cross-matching of at least 2 units of packed red blood cells, and coagulation studies, as well as an electrolyte panel with liver enzymes in the event the patient has a history of hepatic dysfunction. Once adequate resuscitation and correction of any clotting abnormalities have been initiated, the patient can be further evaluated to determine the source of bleeding.

A nasogastric tube should be placed and gastric lavage performed since 11% to 17% of patients with LGIB symptoms can have an upper gastrointestinal source of bleeding. Bilious return should be achieved before the lavage is considered adequate. If no upper gastrointestinal source of bleeding is found, the nasogastric tube can be removed. The anus and rectum should be examined closely with anoscopy and rigid