Not Just Your Typical GI Bleeder

In a Medical Ward

I was on call on the medical ward on a fairly typical night. As team leader, I took nine patients that night, with one more patient needed to meet our maximum of 10 patients. After 10 patients, the back-up resident would take over and evaluate all remaining patients. My nine patients so far were all typical admissions and consisted of three chronic obstructive pulmonary disease (COPD) exacerbations, two congestive heart failure exacerbations, two pneumonias, one syncope, and one patient with new-onset atrial fibrillation with rapid ventricular response.

When I received the last page at 3 AM, I promptly responded. The secretary in the emergency department (ED) answered my call. I informed her that I was the medical officer of the day (MOD) and wanted to find out who had paged me. Hearing the words, "Who paged the MOD?" reverberating in the background made my hair stand on end and gave me mild intestinal cramping, as it would for any fellow resident. I always feel so vulnerable at that moment because I visualize 10 ED residents salivating while they stand in line waiting to present their patients who "need to come in and be admitted" for further evaluation.

The ED resident told me the details of a patient who had just walked into the ED—an 84-year-old man with a history of hypertension, COPD, gastritis, and diverticulosis who had a 1-day history of nausea, diarrhea, and melena. The ED resident, knowing of my ambitions for a gastroenterology fellowship, remarked that this patient was "right up my alley" because he was a "typical GI bleeder." He told me that the patient would be an "easy, straightforward admission."

I made a mad dash to the computer to look up the patient's laboratory work. I moved with extra spark in my step because I knew that I could efficiently evaluate and "tuck in" my patient and sleep at least 2 hours before morning report.

After checking the patient's laboratory work-up, I realized that he was not the typical GI bleeder. His laboratory results reflected a hemoconcentrated state with an elevated leukocyte count of 15,700/mm^3, platelets of 524, 000/mm^3, hemoglobin of 10.5 g/dL, hematocrit 32%, blood urea nitrogen of 36 mg/dL, and creatinine of 1 mg/dL. The patient's records indicated that 1 month before this presentation, his hemoglobin was 13.6 g/dL and his hematocrit was 41%.

After hurrying to the patient's bedside and taking one look at him, I knew that he was in trouble. He was tachycardiac and becoming hypotensive. Resuscitation was well under way—two large-bore intravenous catheters (IVs) were carrying saline boluses, and blood was on its way. The patient became pale and started to show signs of rigor. As central venous access was established, I told the nurse to call a surgeon, a gastroenterologist, and a chaplain.

Just as I returned to the patient's bedside, the nasogastric tube became a continuous flow of bright red blood. Simultaneously, a steady stream of melena spewed out. The melena quickly turned to bright red blood. As I was assisting with central access, another resident was scooping the bloody stool with both hands. He was scooping large puddles every 30 seconds as if he were scooping water out of a rapidly sinking boat. The suction canister was changed three times within 20 minutes. By this time, the patient had two peripheral IVs with saline boluses and two points of central access with blood pouring in. Despite our best efforts, the patient was massively exsanguinating before our eyes. I had the most helpless feeling.

As we feverishly worked to save the patient's life, the chaplain was in the process of reading last rites to him. By the time the surgeon and the gastroenterologist arrived, the patient had become asystolic and required intubation and advanced cardiac life support. We administered 8 units of packed erythrocytes and 8 L of normal saline. After 45 minutes of heroic efforts, the patient's death was pronounced.

Subsequent autopsy revealed two transmural duodenal ulcerations measuring 3.6×1.5 cm and 1.5×2.1 cm, and significant erosions into the gastroduodenal artery were noted. Approximately 4000 cc of intraluminal blood was present within the patient's stomach, small bowel, and colon. A 90% stenosis of the right coronary artery, a 60% stenosis of the proximal left anterior descending coronary artery, and evidence of a previous infarction in the posterior left ventricular wall were also noted. Because of this code, I will always remember that there are no "typical GI bleeders."

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