Gi bleed symptoms merck manual

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The pain may be the only sign of the need for surgery... read more), passing of gas Gas Gas is normally present in the digestive system and may be expelled through the mouth (belching) or through the anus (flatus). There are three main gas-related complaints: Excessive belching... read more (flatulence), loss of appetite Loss of Appetite Loss of appetite (anorexia) implies that hunger is absent—a person with anorexia has no desire to eat. In contrast, a person with an eating disorder such as anorexia nervosa or bulimia nervosa... read more , hiccups Hiccups Hiccups are repeated involuntary spasms of the diaphragm, followed by quick, noisy closings of the glottis. The diaphragm is the muscle that separates the chest from the abdomen and that is... read more , and nausea, may suggest a digestive disorder or another type of disorder. Chest or back pain Chest or Back Pain Pain in the middle of the chest or upper back can result from disorders of the esophagus or from disorders of the heart or aorta (see Chest Pain). Symptoms may be similar. Gastroesophageal... read more usually suggests another type of disorder but sometimes is caused by a digestive disorder. Indigestion Indigestion Indigestion is pain or discomfort in the upper abdomen. People may also describe the sensation as gassiness, a sense of fullness, or gnawing or burning. The sense of fullness may occur after... read more is an imprecise term that is used by different people to mean different things. The term covers a wide range of symptoms, including dyspepsia Indigestion Indigestion is pain or discomfort in the upper abdomen. People may also describe the sensation as gassiness, a sense of fullness, or gnawing or burning. The sense of fullness may occur after... read more , nausea and vomiting Nausea and Vomiting in Adults Nausea is an unpleasant feeling of needing to vomit. People also may feel dizziness, vague discomfort in the abdomen, and an unwillingness to eat. Vomiting is a forceful contraction of the stomach... read more , regurgitation Regurgitation and Rumination Regurgitation is the spitting up of food from the esophagus or stomach without nausea or forceful contractions of the abdominal muscles. Rumination is regurgitation with no apparent physical... read more , and the sensation of having a lump in the throat Lump in Throat Some people feel as if they have a lump or mass in their throat when no mass is actually there. If this sensation is unrelated to swallowing, it is termed globus sensation, or globus hystericus... read more (globus sensation). Airway management and fluid resuscitation, including blood transfusion if needed Endoscopic banding (sclerotherapy second choice) Possibly a transjugular intrahepatic portosystemic shunting (TIPS) procedure Because varices are invariably diagnosed during endoscopy, primary treatment is endoscopic. Endoscopic banding of varices is preferred over injection sclerotherapy. At the same time, IV octreotide (a synthetic analog of somatostatin, which may also be used) should be given. Octreotide increases splanchnic vascular resistance by inhibiting the release of splanchnic vasodilator hormones (eg, glucagon, vasoactive intestinal peptide). The usual dose is a 50-mcg IV bolus, followed by infusion of 50 mcg/hour. Octreotide is preferred over previously used agents such as vasopressin and terlipressin, because it has fewer adverse effects. If bleeding continues or recurs despite these measures, emergency techniques to shunt blood from the portal system to the vena cava can lower portal pressure and diminish bleeding. A TIPS procedure is the emergency intervention of choice. TIPS is an invasive radiologic procedure in which a guidewire is passed from the vena cava through the liver parenchyma into the portal circulation. The resultant passage is dilated by a balloon catheter, and a metallic stent is inserted, creating a bypass between the portal and hepatic venous circulations. Stent size is crucial. If the stent is too large, portal-systemic encephalopathy results because of diversion of too much portal blood flow from the liver. If the stent is too small, it is more likely to occlude. Surgical portacaval shunts, such as the distal spleno-renal shunt, work by a similar mechanism but are more invasive and have a higher immediate mortality. Mechanical compression of bleeding varices with a Sengstaken-Blakemore tube or one of its variants causes considerable morbidity and should not be used as primary management. However, such a tube may provide life-saving tamponade pending decompression with a TIPS or surgical procedure. The tube is a flexible nasogastric tube with one gastric balloon and one esophageal balloon. After insertion, the gastric balloon is inflated with a fixed volume of air, and traction is applied to the tube to pull the balloon snugly against the gastroesophageal junction. This balloon is often sufficient to control bleeding, but if not, the esophageal balloon is inflated to a pressure of 25 mm Hg. The procedure is quite uncomfortable and may result in esophageal perforation and aspiration; thus, endotracheal intubation and IV sedation are often recommended. Liver transplantation can also decompress the portal system but is a practical option only for patients already on a transplant list. Splenectomy is done to treat gastric variceal bleeding due to splenic vein thrombosis (sometimes a sequela of pancreatitis). View All Procedures > Several tests are done to help confirm the suspected diagnosis. Complete blood count (CBC), coagulation profile, and often other laboratory studies Nasogastric tube (NGT) for all but those with minimal rectal bleeding Upper endoscopy for suspected upper GI bleeding Colonoscopy for lower GI bleeding (unless clearly caused by hemorrhoids) CBC should be obtained in patients with large-volume or occult blood loss. Patients with more significant bleeding also require coagulation studies (eg, platelet count, prothrombin time [PT], partial thromboplastin time [PTT]) and liver tests (eg, bilirubin, alkaline phosphatase, albumin, aspartate aminotransferase [AST], alanine aminotransferase [ALT]). Type and cross-match are done if bleeding is ongoing. Hemoglobin and hematocrit may be repeated up to every 6 hours in patients with severe bleeding. Additionally, one or more diagnostic procedures are typically required. Nasogastric aspiration and lavage should be done in all patients with suspected upper GI bleeding (eg, hematemesis, coffee-ground emesis, melena, massive rectal bleeding). Bloody nasogastric aspirate indicates active upper GI bleeding, but about 10% of patients with upper GI bleeding have no blood in the nasogastric aspirate. Coffee-ground material indicates bleeding that is slow or stopped. If there is no sign of bleeding, and bile is returned, the NGT is removed; otherwise, it is left in place to monitor continuing or recurrent bleeding. Nonbloody, nonbilious return is considered a nondiagnostic aspirate. Upper endoscopy (examination of the esophagus, stomach, and duodenum) should be done for upper GI bleeding. Because endoscopy may be therapeutic as well as diagnostic, it should be done rapidly for significant bleeding but may be deferred for 24 hours if bleeding stops or is minimal. Upper GI barium x-rays have no role in acute bleeding, and the contrast used may obscure subsequent attempts at angiography. Angiography is useful in the diagnosis of upper GI bleeding and permits certain therapeutic maneuvers (eg, embolization, vasoconstrictor infusion). Flexible sigmoidoscopy and anoscopy may be all that is required acutely for patients with symptoms typical of hemorrhoidal bleeding. All other patients with hematochezia should have colonoscopy, which can be done electively after routine preparation unless there is significant ongoing bleeding. In such patients, a rapid prep (5 to 6 L of polyethylene glycol solution delivered via NGT or by mouth over 3 to 4 hours) often allows adequate visualization. If colonoscopy cannot visualize the source and ongoing bleeding is sufficiently rapid (> 0.5 to 1 mL/minute), angiography may localize the source. Some angiographers first take a radionuclide scan to focus the examination, because angiography is less sensitive than the radionuclide scan. The American College of Gastroenterology's 2016 guidelines on management of patients with acute lower GI bleeding suggest doing CT angiography to localize the bleeding site before angiography or surgery. Diagnosis of occult bleeding can be difficult, because heme-positive stools may result from bleeding anywhere in the GI tract. Endoscopy is the preferred method, with symptoms determining whether the upper or lower GI tract is examined first. Double-contrast barium enema and sigmoidoscopy can be used for the lower tract when colonoscopy is unavailable or the patient refuses it. If the results of upper endoscopy and colonoscopy are negative and occult blood persists in the stool, an upper GI series with small-bowel follow-through, CT enterography, small-bowel endoscopy (enteroscopy), capsule endoscopy (which uses a small pill-like camera that is swallowed), technetium-labeled colloid or red blood cell (RBC) scan, and angiography should be considered. Capsule endoscopy is of limited value in an actively bleeding patient.

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