AETIOLOGY OF UPPER GASTROINTESTINAL HAEMORRHAGE IN MEDICAL WARDS

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SUMMARY

432 patients were endoscoped for upper gastrointestinal bleeding. Duodenal ulcer was the commonest cause which accounted for 35.2% of the total cases. Oesophageal varices were found in 16.6% while gastric erosions were responsible for 11.6% cases. Other relatively less common causes include severe oesophagitis (5.8%), carcinoma stomach (2.8%) and benign gastic ulcers (3.5%). 21% of the patients had no demonstrable lesion in the upper gastrointestinal tract.

INTRODUCTION

Upper Gastro-intestinal Bleeding [UGIB] is a common medical emergency[1,2,3]. Many hospitals in the world have adopted a policy which entails an early diagnosis of the cause of upper G.I. Bleeding by performing an emergency endoscopy. In this way appropriate measures can be taken to stop the bleeding and prevent its recurrence in many cases. With the widespread availability of routine and emergency endoscopy services it is possible to reach a correct diagnosis in over 80% of the cases. Once the cause of the bleeding is ascertained, a combined medical and surgical management is preferred by many gastroentrology centres in the world[2,3]. The aetiology of upper G.I. bleeding varies in different parts of the world depending on the incidence of the different diseases in a particular area such as chronic liver disease, primary gastro-intestinal diseases and the use of steroidal and non-steroidal anti-inflammatory drugs. We are reporting the results of 473 patients who had presented with haemetemesis and or malaena in this study.

MATERIAL AND METHODS

473 patients who presented with Upper G.I. Bleed were admitted to Med. A Unit L.R.H. (P.G.M.I.) Peshawar and Med. B Unit K.T.H. Peshawar from June 1990 to June 2000. The patients were admitted

through Out-Patient and Accident and Emergency Departments of the two hospitals. After necessary resuscitation, 432 patients were endoscoped. 41 patients were not willing for endoscopy. All the gastric lesions were biopsied where malignancy was suspected. No complications were encountered. The age of patients ranged from 10 to 80 years.

Male	Female	Total
266	166	432

TABLE - 1

RESULTS

The results of the 432 patients endoscoped are as follows.

DUODENAL ULCER

Duodenal Ulcer was the commonest lesion observed. It accounted for 35.2 %(n=152) of all the cases. 123 patients (80.9%) were male and 29 patients (19.1%) were female. 59.8%(n=91) of all the patients who had DU were aged 40 years and above.

Male	Female	Total	%age of total (432)
123	29	152	35.2

TABLE - 2

OESOPHAGEAL LESIONS

OESOPHAGEAL VARICES

16.6%(n=72) had oesophageal varices .50(69.4%) were male and 22(30.6%) were female. In 70 patients (97.2%), the cause of oesophageal varices was cirrhosis of the liver. In 2(2.8%) no cause could be ascertained for oesophageal varices.

Male	Female	Total	%age of total (432)
50	22	72	16.6

TABLE - 3

GASTRIC LESIONS

51 patients (11.8%) had gastric erosions. Of these 28 (54.9%) were male and 23 (45.1%) were female. 40 (78.4%) patients were above the age 45 years. 12 patients (2.8%) had carcinoma of the stomach out of whom 10(83.4%) were male .6 men and one woman were from Afghanistan. 15 patients (3.5%) had benign gastric ulcer. 10(66.7%) were male and 5(33.3%) were female. All were above the age of 35 years.

Male	Female	Total	%age of total (432)
28	23	51	11.8

TABLE - 4

OTHE OESOPHAGEAL LESIONS

25 patients (5.8%) had severe oesophagitis. 14(56%) were male and 11(44%) were female. Oesophageal carcinoma was found in 9(2.1%) patients out of whom 7 were Afghan refugees.[7] were male and 2 were female. Evidence of Mallory-Weis syndrome was found in 5 patients (1.1%). 2 were male and 3 were female.

MULTIPLE LESIONS

Of the above 17 patients who had Duodinal Ulcers, 9 had oesophagitis, 3 had oesophageal varices and 5 had gastric erosions. The source of bleeding in these cases could not be ascertained. [These patients have been counted in DU Table 2]

NO LESION OBSERVED

In 91 patients (21.1%) no lesion could be seen in the upper gastro-intestinal tract. 42 (46.2%) were male and 49(53.8%) were female. 64 patients (70.3%) in this group were aged 10—40 years.

Male	Female	Total	%age of total (432)
42	49	91	21.1

TABLE - 5

DISCUSSION

Haematemesis and malaena account for a considerable proportion of hospital admissions. Most such patients are admitted to medical wards (1-3). Combined medical and surgical management of these patients is an effective way of managing these patients[2,3]. Since there are many cases of upper G.I. bleeding, an exact diagnosis of the cause of bleeding must be ascertained for proper treatment of these conditions and to prevent recurrence of bleeding. Fibreoptic endoscopy plays a very important role in the diagnosis and curative measures. It has advantages over the contrast radiological studies of the upper G.I. tract because the lesions can be visualized as well as biopsied when desired[4,5]. It is widly available in our country. It should be performed as soon as the patient is resuscitated. It may show ulcers which are actively bleeding and require urgent surgical intervention. The complications in experienced hands are rare[1]. Upper G.I. endoscopy also has therapeutic value such as sclerotherapy for oesophageal varices[7,8]. In our study gastric erosions and duodenal ulcer was the cause of upper G.I. Bleeding in 47% of the patients and this is comparable to the findings in the West. (2-3S). Our findings are also similar to a study of upper G.I. bleeding in Karachi[9]. 16.6% of the patients had bled from oesophageal varices. This is different from the 10% in the U.K. This can be explained by the much higher incidence of cirrhosis liver due to Hepatitit B and C viruses in our country compared to that in U.K and vaccination against Hepatitis B virus has started only recently in our country[10-12]. This also emphasises the fact that patients needing endoscopy should be routinely screened for Hepatitis- B and C viruses so that these infections are not inadvertently spread to the non infected patients. For the same reasons adequate sterilization of the endoscope is also very important.

No lesion was identified in 21.1% of our patients. Normal upper G.I. Endoscopy of the patients who had haemetemesis and malena are common in other studies as well. Factors such as delay in referring for endoscopy and pre-endoscopy treatment with potent anti-ulcer therapy may be responsible for such findings[1,13,14,15]. We conclude that upper G.I. Bleeding is common in medical practice[1]. All such patients should be endoscoped and the aetiology of the bleed should be investigated for optimal management.[4-6]. Upper G.I. endoscopy is very safe in experienced hands.

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