Yan Yu, 2017 (www.yanyu.ca)

Lower GI Bleeding DDx

(Fecal occult blood test positive, BUN will be normal)

Diverticulosis (30-50%)

Out-pouchings of colon wall; the strain bursts the capillaries within.
Most: painless belly, previously well.

Vascular

Angiodysplasia (20-30%)

Abnormal growth of vasculature rising to the colon mucosa.
Tx: endoscopic cauterization

These two are abrupt lower GI bleeds (Acute, <2-3 months); they do NOT cause iron deficiency!
*They're seen mostly in **older people***

Anorectal (esp <50 yrs old)

BRBPR, Blood NOT mixed in with stool! On toilet paper, or dripping into bowl

Fissures
→*pain*!!
→spasms!

Hemorrhoids
→*Internal* – no pain, bleeds!
→*External* – blue skin tags; painful if thrombosed, usually won't bleed

Solitary rectal ulcer

Anal cancer
→bleeding, discharge
→presence of mass
→pruritus

Fistula/Abscess
→Will bleed if abscess ruptures

Neoplasm

→**Colorectal cancer (CRC)** – *often asymptomatic, healthy, >40, w/ **iron deficiency anemia**!*
→small bowel tumors (almost always benign)
-blood **usually** *mixed in with the stool*

Inflammation (Colitis – up to 30%)

Ischemic
(usually affects splenic flexture – not well vascularized region of colon)

IBD
(Crohn's, UC)
Chronic!

Infections of colon
Short-term!

- Lower GI bleeds usually less severe than Upper GI bleeds
  - 80% stop bleeding on their own
  - mortality only 5% (much lower)
- Dx:
  - Made by plain films (thumb-printing), nuclear scan, abdominal CT, angiography.
  - Confirmed, and often treated, with colonoscopy

Indications for surgery:

- Failed medical mgmt (i.e. colonoscopy, angiography)
- Prolonged bleeding/significant loss (>6 units of pRBCs in short period of time, fast bleed, hypotension)