Yan Yu, 2017 (www.yanyu.ca)

Upper GI Bleeding DDx

(coffee-ground emesis/melena = usually slow, low-volume, venous bleed)
(hematemesis/hematochezia = usually acute, large-volume, arterial bleed)
(BUN will be high – diff from lower GI bleeds)

R/o excess anticoagulation (i.e. coumadin, heparin), DIC, and congenital bleeding dx

Esophagus

Esophagitis, and **esphageal carcinoma (rarer)**

Ruptured Esophageal Varices – (15%)
(varices caused by portal hypertension from scarred liver, which are then ruptured by food passing through esophagus)
Tx: banding/ligation, octreotide (↓ blood flow to region)

GE Junction

Mallory-Weiss Tears:
Retching and vomiting repeatedly force open the GE junction, tearing it.
Tx: inject epinephrine (vasoconstriction); clip tears together (self-healing)

Stomach

Gastritis:
Due to stress, EtOH, etc
Tx: PPI, H2 blocker, antacid (↓ acid and ↓ reflux)

Peptic Ulcer Disease (55%)
(where acid overwhelms GI mucosal defense)
Sx: 30% asymptomatic, epigastric pain radiating to back, pain correlated w/ eating, N/V, early satiety
Tx: PPIs, H2-blockers; endoscope: cauterize, clipping, epi-injection; surgery.

Hypersecretion (Zollinger-Ellison ZE syndrome)
Gastrinoma (gastrin-producing tumor) in duodenum or pancreas (**rare)**

Extreme stress (ICU settings), other stomach cancers, and other contributory factors **(rare)**

NSAIDs
-ASA (asprin), ibuprofen (motrin, advil), naproxen
-↓ protective prostaglandin production, ↓ blood flow to GI tract.
-4% duodenal, 24% gastric

H. pylori
-Irritates antrum, inducing massive H+ secretion, overcoming mucosa defense.
-95% duodenal, 70% gastric
-**Tx:** Hp Pac – PPI, amoxillin, clarithryomycin

Duodenum

Cancer (almost always benign in duodenum)

Indications for surgery:

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