Commentary

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Patients Admitted To the Intensive Care Unit Affected By Acute Upper Gastrointestinal Bleeding

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Description

Acute upper gastrointestinal bleeding is a common medical emergency with a hospital mortality rate of 10%. Older patients and people with chronic diseases tolerate acute upper gastrointestinal bleeding worse than younger and better fit patients, and are at higher risk of death. Almost all people who develop acute upper gastrointestinal bleeding are treated in the hospital, and therefore the guide focuses on hospital care. The most common causes are stomach ulcers and esophagogastric varices. Endoscopy is the main diagnostic test in patients with acute upper gastrointestinal bleeding.

The data obtained from the medical history were: age, sex, personal history of arterial hypertension, and diabetes with established coronary disease, heart failure with reduced ejection fraction, chronic renal failure, and use of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) in recent years. 3 months, alcoholism, cirrhosis (early diagnosis or diagnosis during hospital stay), previous gastrointestinal bleeding, type of clinical picture (hematemesis, melena, hematochezia, acute anemia, hypovolemic hemorrhagic shock, need for transfusion of blood products), etiology (gastric ulcer , duodenal ulcer, erosive gastritis, gastric cancer, duodenitis, gastric cancer), Mallory-Weiss syndrome, esophageal varices), endoscopic study performed, surgical treatment, medical treatment and mortality.

The mean age was 48.35 years. In the descriptive analysis of the baseline characteristics, we found that 33% had a history of gastrointestinal bleeding, 18% had used NSAIDs, 28% had end-stage liver disease (cirrhosis), and 10.5% had therapeutic anticoagulation. Regarding the clinical presentation of gastrointestinal bleeding, melena and hematemesis were the most frequent manifestations (78.4% and 72%, respectively), followed by acute anemia (47%). 38% showed hemodynamic instability (hypovolemic / hemorrhagic shock). The total cases of UHD, 35 episodes were related to varicose veins (45.8%) and 39 cases had an origin not related to varicose veins" (54.16%). The general causes of gastrointestinal bleeding were duodenal ulcer (18%), gastric ulcer (25%), esophageal or gastric varices (39%), gastric cancer (10.6%), Mallory-Weiss syndrome (2.4%), and duodenitis (1.6%).

The epidemiology, etiology, and outcome of upper gastrointestinal bleeding vary significantly in different geographic regions, depending on the demographic and socioeconomic characteristics of the local population. More than half of patients with gastrointestinal bleeding have a concomitant disease and, according to the literature, the most common of these diseases are high blood pressure, diabetes mellitus, coronary artery disease, malignancies, and liver disease. The clinical guidelines published in Scotland in 2008 reported a mortality rate of 4% in patients with gastrointestinal bleeding without comorbidities, with a death rate from heart failure 1.8 times, from neoplasms 3.8 times and from liver disease doubled. According to the 2012 guidelines of the National Institute of Health and Clinical Excellence, patients with gastrointestinal bleeding who also suffer from chronic conditions have an increased risk of death, findings where the percentage of non-variceal upper bleeding reached 61%.

In a comparative study of two cohorts of patients with UHD (period 1983-1985 and 2002-2004), Loperfido et al. showed that the mortality rate for this entity decreased from 17.1% to 8.2%. Currently, it is estimated that the mortality from UGH is 7% to 12%, and it can reach 30% or more in the case of bleeding due to esophageal varices.

Conclusion

In conclusion, the objective of our study was to identify the demographics, personal history, mode of presentation, causes, and mortality in several cases of upper gastrointestinal bleeding admitted to an intensive care unit. The most frequent causes were gastroduodenal ulcers, followed by bleeding due to varicose veins.