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There are no notes on the slide. ManeClassification and External ResourcesPeciality generalgastroenterology surgeryCausas superb digestive hemorrhage-10 K92.1C1E-9 578.1MedlinePlus 0031 30 Medical notice edit data on Wikidat Manet is the expulsion of black sediments (faeces), viscous and smelly due to the presence of degraded blood from the upper digestive tract (mouth-corner duodenoyunal). Bloodthirsty, a product of bleeding from the upper digestive tract that covers the esophagus, stomach and first part of the duodenum, taking a coloration often referred to as resin. Digested blood in the stomach causes the stool to become black, which is usually a signal of poor nutrition, stomach problems. When bleeding occurs from the second part of the small intestine, colon or rectum, bruising may occur, which, unlike mana, is a wine-red-haired deposition. If there are signs of anemia, a stool hidden blood test can be offered. In case of bleeding very quickly or massive they can take a dark mahogany color. There will often also be - associated with mana - vomiting with blood, called hematemesis, which involves active bleeding, whether from ulcers, rupture of the esophageal varicose veins, Mallory-Weiss tears, etc. Mana production requires at least 50-80 milliliters of blood. Links www.righthealth.com dictionary.sensagent.com www.harrisonmedicina.com data: No1163908 Received from (medicine) -Oldid-125345874 Hemorrhage in digestion 10.1. HIGH DIGESTIVE HEMORRAGIA Drs. Germ n Cabrera Romero, Vctor Macedo Pe a DEFINICI N This is a blood loss caused by various diseases that affect the digestive tract from orofarx to The Trace ligament. Because of its p rrida volume may be: Soft digestive hemorrhage (chronic anemia), Moderate digestive hemorrhage, Massive digestive hemorrhage (30-40% of the volume of sangu neo). This can happen as: Hematemesis: V myths of fresh blood is not digested secretion g strica, hemorrhage between Orofaringe and Treitz and can be accompanied by Manet. The car depends on bleeding: - From the place of bleeding, - From the speed of bleeding, - From the speed of emptying g strico - It can be: Macrosc pica and microsc pica. Manet: Banishing the black chair - it requires 50-150 ml of bleeding to produce it. Tarding the color of the hemorrhage tube this is due to the production of hematin cide under the influence of salt acid on hemoglobin or the production of sulfide from HEM. Under the influence of hydrogen sulfide on iron Hb. Manet without hematemesis usually indicates the dystal hair of the parrot. 1. ETOLOGIST A 1.1. Ptica lcera 50-75% of cases. Duodenal lcera hemorrhage is 4 times more common than lcera g strica, but both have the same tendency to bleed. Massive hemorrhage has a frequency of 10-15% and is usually produced per hour by the inflammatory process of the regional artery. Location: a) Duodenal Bulb. b) A small curvature. c) A rich pre-pilot area. Of these, a slight curvature makes mass bleeding more frequent, but the duodenum is generally the most common. The relationship between the location of lcera and the severity of bleeding due to lesin major arteries, minor curvature, coronary stim quik, rich saws and gastroduodin. Mechanism: (a) Acute fibrosis with intense vasodilation of the lesion by in advance in ulcerative destruction. There's going to be diffuse bleeding. b) Angioterebrante lcera: with artery lesi n. This damage is more important and has more serious consequences. In addition, there is a spontaneous hemostas, which depends on the formation of an obstructionist co gulo in the vascular bed. This favors hypotensi n, increases posthemorrhagia sangu nea coagulability and there is a decrease in arterial light by pulling the fibro-muscle layer and winding the endothelial layer. 1.2. Acute lesions of the mucosa/ gastritis These lesions may be: single or multiple (the most common). Make the whole mucous membrane (hemorrhagic necrosis). They do not reach the muscle part of the mucosa; they are not real. The most common location: the body, background and curvature are larger as opposed to benign lks, which are located in the den and minor curvature. Lkeras estr s: They are in this area and are acute gastroduodenal lesions, shock, postoperative septicaemia, traum ticas or burns. In this case it does not increase the salt acid or secretion of strica, but reduces the flow of sangu neo spl cnico; The yes or isquamico surface g strica mucosa occurs. In addition, sepsis causes an anomaly in both coagulation and administration: Long-term corticosteroid therapy. Non-steroidal anti-inflammatory drugs. Alcohol: secretagogo g strico. 1.3. V Rice Esof gicas Is the most common cause of bleeding in patients with cirrhosis of the liver or extrageptic vein obstruction port The port of the vein). Features: Brusca and Massive. Blood loss is rare. It can also be: acute hepatitis or hepatic fat infiltration. Factors that state bleeding are: increased pressure in V rice and post-esophagitis. 1.4. Hiatal hernia can accompany hidden bleeding. Rarely massive bleeding. This is caused byptic esophagitis due to reflux. Neoplasma is not a regular cause; bleeding associated with c ncer g strico is caused by erosion of n vessels underlying the tumor. This is usually the case; mild moderate. It is massive when large glass is eroded and can be a major symptom of 1.6. Tear Sof gica Mucosa s ndrome Mallory-Weiss Mucosa laceracin takes place in the area uni n esofag strica. Then there will be arcades and non-gemtic myths. Then hemathesis. 1.7. Vascular lesions s ndrome de Randu-Osler-Weber, angjoma, hemorrhic telangiectasias. 1.8. rricos Arterioscler ticos Aneurysms can rupture in the small intestine. 1.9. Sangu neas Primary vasculitis dyssion and connective tissue disorder. 1.10. Uremia is associated with a hidden hemorrhage of cr nica by diffuse affectation of the mucus of the holy magician and the small intestine. 2. CL NICO TABLE - In many cases, a history of previous or nico digestive suffering or accidental diagnosis can be found. - In more or less 40% of cases, there are signs that precede a hemorrhagic episode: 60% of patients experience bleeding without symptoms produced. In the other group there is no chronic or premorrhagic digestive history, this is the first manifestation of the disease. - The classic signs of external bleeding are: Hematemesis and mana But there is an intermediate time between endo-visceral hemorrhage and its externalization depending on the severity, which may be silent or present as acute hypovolemia. - The recent consumption of alcohol in large quantities or the use of anti-inflammatory drugs raises suspicions of erosive gastritis. If alcohol consumption is cr nica, the most likely cause is V rice esof gicas. Taking aspirin gives us gastroduodenitis, plyce and bleeding. - The previous history of digestive hemorrhage with family history gives suspicion of bowel disease or hemorrhagic thesis. - The presence of previous arcades followed by hematemesis: s ndrome de Mallory-Weiss. - If there is a localized or diffuse associated with pain: - acute lcera or reflux or nica. Code type: Diverticulitis, infections. Painless bleeding: the most common disease associated with v rice Angiodisplasia. Sudden, acute, disproportionate pain associated with abdominal palpation: discard visceral perforation. Right upper quadrant pain with bleeding: Discard the cycles and think about post-traumatic gemobility that causes a hepatic rupture. - S ntomas sist micos: Fever. Escalophre can be associated with infectious inflammatory causes. Weight loss. Neoplasia. Examination of F shiko anemia component and reactionary vascular, skin and mucous pallor. Paleness with a yellowish tinge: impregnating fabric hem lysis and bilirubr nica. D ficit de perfusi n cut nea: Disto-coldness. Delaying the redness of the nail bed. Psychotic hyperactivity: Sweating fr a. Circulatory disorders: Hypoperfusi n encef lica: dizziness, apnea, dizziness, blurred vision, hum two or two. The amount of hemorrhage (the total volume of blood of the average person is about 8% of his total body weight). CLASS I: Less than 15% of lost volume: normal scanning. CLASS II: 20-25% blood loss. Pulse m with 100/minute. Pulse pressure has decreased. A thirsty and anxious patient. CLASS III: 30-35% blood loss. Pulse m with 120/m of airway with 30/minute. Reducing pressure, oliguria and embarrassment n. mental. CLASS IV: 40-50% blood loss. Pulse m with 140/minute. P.A.: Sist lica less than 50 mm Hg. Art. F.R.: m with 35/m. Anuria, great mental confusion, lethargy and coma. 3. TREATMENT HIGH DIGESTIVE HEMORRAGIA This is an extraordinary M dico-quer rigica, a great value and frequency whose morbidity and mortality are influenced by timely, consistent management, in which several professionals are sure to attend where possible organized as a team. It is clear that command and identification of high-risk patients are becoming the most important weapon in the current management of this pathology. PHASE I: REANIMACI N This stage consists of: 1.- The implementation of the school history and completed. 2.- Specific resuscitation activities. 3.- Request for former menes assistants. These actions are performed simultaneously and have as their goals: Stabilization of the patient's haemodinologically and determine the initial risk criteria of the pron stic. Diagn stico nico is made by presence: Hematemesis. - Very simple procedures are very useful for diagnosis: - Early installation of the nasog strica probe (SNG). - A rectal touch during the F sico exam. Specific measurements include: - Keep a constant rea to protect it from aspiration, v myth or blood by washing g strico. Tracheal intubation can be performed on a patient with heavy bleeding and repeated a large amount of hematemesis, in patients with severe shock and sensory alternation, as well as in those with psychomotor arousal and hematemesis. - Access to the case through the corresponding rich V perif and/or central V. This ultima is needed for elderly patients with cardiorespiratory diseases and patients with a suspended hypovolumic shock, because it is not allowed to rearrange the neo-lost volume, but also the monitoring of central venous pressure (PVC), this central V allow for the rational administration of cysts and early diagnosis of the hospital's re-expansion, as during the episode of the expansion of PVC drops 4 cm water or zero for less than 4 hours. - The administration of the bull geno should be routinely used in the elderly and hemodynamically unstable patients with levels of Hb less than 10 grams % and here with the known heart disease is excluding. In addition to the above it should be: Place S.N.G. to check the presence or not of blood and washing before an emergency endoscope. The uretrovesic probe to monitor urine volume, which should be maintained in numbers, is more than 0.5 ml/kg/h. Monitoring vital functions. Auxiliary ex-men seek to check the overall dispassionate significant bleeding, control potential complications and detect comorbidities. Should be requested: Hb, Mcto., Hgrm. Group sangu neo and Rh, platelets, electrolytes, heptoly biocysmics, arterial gases and ECG, in elderly people with known cardiore-pitoria diseases and hemodynamic instability. STAGE TWO. ENDOSCOPIA DIAGNOSTICA The value of an emergency endoscope has already been established, an effective diagnosis is about 90%, especially if it is performed within 12 hours of bleeding evidence. The most common cause of high digestive hemorrhage with percentage variations depending on the population surveyed are: Acute mucous membrane lesi n g strica (L.A.M.G.), ptica lcera (Duodenal-G strica) and v rice esof gicas, which account for about 80% of the causes of this ndrome s; are less common causes: C ncer g strico, Mallory-Weiss ndrome s, esophagitis, etc. This test allows you to identify endosque peak signs of pron stic value applied to patients with lcera and L.A.M.G., as well as in ndrome Mallory-Weiss, tumor and vascular lesions. The frequency of relapses or constant bleeding is very high, approximately In patients with Forrest I and IIa, less than 10% in Forrest IIb and zero in Forrest II. If the patient did not receive peak endosque treatment about 30% of patients with active bleeding and visible vessel require emergency surgery. WORK III. MEDICAL AND ENDOSCOPIC TERAPEUTICA H2 blockers of rmacos elesin in the treatment of H.D.A. by ptica lcera, although not all works show that stos control acute or relas-grade bleeding. Non-endosc pica therapy for esophageal bleeding V rice includes: modified Sengstaken-Blackemore bal n, vasopressin and nitroglycerin, somatostatin (which reduces PA) and metholopramide, which increases presi n lower esophageal esf nter, for reasons these treatments are being questioned. Since the highest hospitalization rate is performed within 48 hours, oral V removal should be maintained during this period, allowing further completion of any therapeutic procedure to peak endosc. Sclerotherapy is a perfectly established procedure in the treatment of bleeding esophageal V rice, the effectiveness in combating effective bleeding varies from 74 to 100%. STEP IV. CUIRUGRIC TREATMENT Timing instructions and the technique to be performed are the main pillars of the right decision. Techniques that need to be performed n according to the experience of the surgeon and the surgical risk of the patient. Such as: Vagotom troncular piloroplast a, m s r pida and less traum tica, eliminates the Vagal factor, low postoperative mortality, but high rates of recurrence of bleeding. Vagotom a m s Gastrectom a and Sutura de la lcera: Gastrectom subtotal Bilroht I, resection in cu a de lcera v sof gicas pic: Sengstaken or Linton probe. Modified deconaction technique or modified Tanner. 4. HIGH RISK CL NICOS CRITERIA 1.- Age: 60 to 2.- Important comorbidities: - Frequent hospitalizations. - Repeated hematemesis. - Frequent mane. - Abdominal pain. - Hematokesia - Orthostatic changes start r pido. 3.- Paleness - Hypotensi n sist lica less than 100 mm Hg. Art. - Hypotensi n orthost tica: ca da la presi n sist lica over 20 mm Hg. Art. - cardiac: tachycardia above 100/m. - Rutile red blood S.N.G. 4.- Blood transfusion (units) - First 24 hours (4 u) - With 2 episodes of bleeding - Transfusi n a total of 6 to 8 units - Marks Endosc peaks ForREST I Pron stic Value: The presence of active bleeding. Ia: Reactive bleeding. Ib: Bleeding in the bath. FORREST II: Recent stigma or recent bleeding. Iia: Visible non-bleeding vessel. IIb: Indirect signs: flat, red or blackish spots, on an ulcer background or with a dark gulo attached. FORREST III: No hemorrhagic signs on lesi n. 5. PROCEDURES ENDOSC PICOS IN HIGH DIGESTIVE HEMORRAGIA - M all endoscopes peaks: 1.- M all requiring contact with fabric: a) T techniques inyection endosc pica, b) Electrocoagulation, c) T rmica probe, d) Ligatur clips. 2.- M all that does not require contact with tissues: a) Photocoagulation with gray, b) Electrohydrothermosond, c) Endosc peak spray techniques. Technique Inyecci n Endosc spades Sclerotherapy: All sclerosing agents qu micos with strong irritating tissue properties. The ideal direction of the sclerosis is determined by its safety and its effectiveness. Sclerosing agents can be divided between derivatives of fatty sidos: ethanolamine and synthetic agents: polydocanol. Electrocoagulation uses a high-frequency current that flows through an active electrode applied to the bleeding nose. The current is converted into heat, causing coagulation due to the high energy density at the point of contact between the electrode and the tissue. The current returns after the plate, establishing a wide rea of contact with the patient. The endosc of the peak bipolar electrocoagulation uses two active electrodes that are applied close together. T rmica probe: The most effective hemostasis and the lowest lesi n are obtained by one-second applications from 150 to 160 C. This thermotherapist duck reaches hemostasis in 80-90% of patients. 10.2. LOW DIGESTIVE HEMORRHAGE This digestive bleeding from the corner of Treitz, manifested by mana, enteroragia and priest, he said that in the lower digestive enterorhagia bleeding prevails over cases of mana (red wine, Nasog strica tube that gets clear bile in succin discards high digestive bleeding, and may not be 15% error. Low weight of digestive hemorrhage is less common than high bleeding, usually type cr nico and intermittent, but in the present they have a difficult diagnosis. To diagnose low bloodbles, you must have the same criteria used in diagnosing high digestive hemorrhage. There are no accurate data on frequency and incidents; report funicular bleeding as the most common cause of bleeding in the stage. If there is a suspicion of low digestive bleeding, it is necessary to make an accurate diagnosis of the point of bleeding in order to perform the appropriate method. History or well-executed clinical examination, nasog strica tube eliminates high bleeding. Study of endosco pico, proctoscope in rectorrascias, colonoscope with fibroscope a. Gammagraf A, using tecnesium 99 injected into v to endove-nosa, computerized studies of ficos gammagr obtained teaching the bleeding site, yields positive results even with bleeding 1 ml per minute, a great help in identifying the bleeding point in the small intestine and right colon. Arteriograf a: Using the upper rich mesent artery, it also gives a diagnosis of location, but the logos of expert radii are needed. Rx study, using to confirm a possible decent stico after stopping bleeding; distract the donkeys and the tusuception. 1. CAUSES OF SANGRAING Diverticular colon disease, can bleed massively, are patients over 60 years old, may have dark blood loss or a priest, diagnosed with a colonoscope a. Treatment: monitoring and cholect left. Colon C ncer, cases of massive bleeding of the left colon are rare. Treatment: hemicolecitis a. Arteriovenous malformations, angiodysplation sicas lesions or vascular tumors, can bleed profusely, usually located in the right colon, in people over 60 years to you colonoscope and colon X-ray gives us a diagnosis. Arteriograf gives great usefulness in the right colon and in Mekel fun in people j venes; use Technesia 99 to confirm the diagnosis (Gammagraf a). Colon lipo are common in both and ulcerative colitis can bleed. When bleeding lcera t fica, in patients carrying typhoid fever, j venes with bleeding fica lcera, with several pains, including in the blind and ascending colon, hemiclect should be done on the right and part of the terminal ileon with anastomosis and ileoklika. In F stula Aorto bowel, with massive bleeding in patients who preceded, being operated on with transplants abdominal aorta. This is a serious picture. The general diagnostic and medical treatment is similar to the procedure used for high digestive bleeding. The main haemorrhage patients requiring transfusi n sangu nea 4 joined-des (500 ml) or m s for 24 hours are cirug tax. The site m s com n bleeding, due to angiodisplasia, is the cecal, which is referred to by many authors; to justify the emp-rich hemicolecotom on the right that controls the bleeding. On the operating table: Washing the intestines and colonoscope for intra-surgery, it can help to determine the exact place of bleeding, if the patient's condition is stable, with the tube cecostom or at the base of ap ndice removi ndo sta or manage through ste soluci n tibia saline to cleanse the colon (aspiration with great care), then colonoscope for v to the to the identification of the point of bleeding and as the execution of the cholectomy. 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