AHD: Upper GI Bleeding (UGIB)
Facilitator Guide

CASE 1

Mr. Pud is a 68 y/o Caucasian male with obesity, chronic back pain, and tobacco use who presents to the ED for 3 days of abdominal pain and dark sticky stools. He has had epigastric abdominal pain for years but notes worsening pain over the past 5 days.

1. What are this patient's risk factors for peptic ulcer disease? Does he have any risk factors for a poor outcome?

2. What other questions do you want to ask the patient and why?

The ED obtains basic labs seen below. You speak to the patient and obtain more information. Your physical exam is as follows.

More HPI

Pt started taking baby aspirin 8wks prior after friend had a heart attack. He uses extra strength ibuprofen 2-4x daily for his lower back pain for the last three months. No other med use. He is having 4-8 episodes of melena per day for 5 days. He endorses intermittent lightheadedness but no syncope. He has had no prior episodes of GIB; no prior colonoscopy or EGD in the past. Drinks one beer every 1-2 weeks.

Physical exam

VS: T 98.7, RR 14 satting 98% on RA, HR 111bpm, BP 120/80 mmHg laying 110/75 mmHg standing
GEN – AOx4, appears mildly anxious
HEENT – Normocephalic. PERRL, conjunctival pallor.
HEART – sinus tachycardia, regular rhythm, no murmurs, rubs or gallops.
CHEST – lungs are clear to auscultation, no rales
ABD – round, central adiposity, hyperactive sounds, soft but moderately tender to palpation at epigastrium
RECTAL– black tarry stool. No hemorrhoids, fissures.

Labs

WBC 13,000	Hb 9.1 mg/dL	Hct 27%	Plt 195,000	MCV 85
Na 137	Cl 10	BUN 45	Glucose 129	
K 4.1	HCO3 22	Cr 1.0		

3. What are the most important features of the exam and labs? Do any of these help you diagnostically? (Consider which findings have the best positive LRs.)

4. Is there any utility for sending the stool to the lab at this point for FOBT or FIT testing in this case?

5. What is your most likely diagnosis?

- Leading diagnosis likely UGIB, specifically PUD in setting of NSAIDs, ASA, time course.

Let's discuss some other differentials for this case as well as clinical features of each diagnosis.

Cirrhotic patient with esophageal variceal bleed	
	Multiple episodes of retching followed by hematemesis; longitudinal mucosal tear seen on EGD
	Prosthetic abdominal aortic vascular graft; may be associated with a herald bleed, often associated with graft infection
	Dilated aberrant submucosal artery, characterized by self-limited (but often recurrent) episodes of bleeding
	Elderly, persistent occult blood loss anemia with a negative colonoscopy; may require angiography or capsule endoscopy for diagnosis.
	Chest pain worsened by swallowing, PO antibiotic use (especially doxycycline), increased incidence in those with left atrial enlargement
GERD	
	Middle-aged smoker with long-standing untreated heartburn who presents with weight loss, early satiety.
	A cause of acute or chronic gastrointestinal blood loss in the elderly and endoscopically described as 'watermelon stripes.' No clear etiology; some association with cirrhosis.

6. Discuss how you would assess and treat this patient.

The GI fellow pages you s/p EGD. What do you plan to ask about the procedure and why?

7. You are ready to discharge the patient 72 hrs later. What are key patient instructions and actions?

****Bonus question**
What if the patient is on anticoagulation? (Note, this question was removed from the 2020 learner guide but can be discussed if there is time).

8. Biopsy results come back after patient is discharged and are positive for H pylori. You create a phone encounter in Epic, call the patient, and write a brief note. What do you need to ask the patient before prescribing and what meds do you send to the pharmacy? What do you tell the patient?

Case 2:

Mr. C. Roses is a 55 y/o m with DM2 (HbA1c 8), untreated HCV, cirrhosis decompensated by ascites and HE. Has never had a GI bleed but had varices on his last EGD 2 months prior. Patient is being admitted for altered mental status. You go see him in his room and witness him vomiting about ½ a cup of bright red blood into bedside basin!

Physical Exam:

VS: T99, HR 122 bpm, BP 98/52, RR 18, SPO2 96%
GEN – appears anxious, diaphoretic
HEENT – Normocephalic. PERRL, conjunctival pallor.
HEART – sinus tachycardia, regular rhythm, no murmurs
CHEST – lungs are clear to auscultation, no rales
ABD – round, mildly distended
SKIN – +spider angiomata, palmar erythema
NEURO – AOx4, no asterixis

Labs:

WBC 11.9 Hgb 7.1 (10.1 two months ago), Hct 20, Plt 98
Na 130, Cl 89, HCO3 28, BUN 42, Cr 1.3, glucose 70
Bili 2.1, Alb 2.9, INR 1.9

1. Write down your problem representation for this patient and compare answers in your group. As a reminder, a problem representation is a 1-2 sentence summary of the case using semantic qualifiers (tempo/duration of illness, characteristics of symptoms) that will help frame your thinking about the patient.

2. What is your working diagnosis?

3. Cirrhosis refresher: What is your initial treatment plan for this patient?

4. Patient arrives to MSD and has at least 500 cc of hematemesis with clots. What is your next plan of action?

Case 3:

70 y/o male patient with a history of CKD, CAD, COPD and GI bleed presents from nursing facility due to fatigue and streaks of blood in his stool. Patient was recently hospitalized for a lower GI Bleed. During that stay patient received a blood transfusion and his Hgb stabilized. As an outpatient he had both upper and lower endoscopy which did not show a potential source of bleeding.

Physical exam

VS: T 98.7, RR 14 satting 98% on RA, HR 98bpm, BP 125/80 mmHg

GEN – AOx4, appears comfortable

HEENT – Normocephalic. PERRL, no conjunctival pallor.

HEART – sinus tachycardia, regular rhythm, no murmurs, rubs or gallops.

CHEST – lungs are clear to auscultation, no rales

ABD – soft non-tender to palpation

RECTAL– Brown stool with some dark blood mixed in. No hemorrhoids, fissures.

Labs

WBC 9,000 Hb 6.5 mg/dL Hct 27% Plt 195,000 MCV 85

Na 137 Cl 10 BUN 45 Glucose 129
K 4.2 HCO3 25 Cr 1.8 (baseline 1.5)

1. What are the important parts of this patients HPI? What else do you want to know about this patient? What do you make of the previous History of GI bleeding? What is on your differential?

2. What do you do next? What studies or procedures would you recommend?

3. You consult GI a upper and lower endoscopy are negative. Overnight you are called to bedside due to tachycardia. When you arrive, patient complains of lightheadedness and shortness of breath. You note a pool of blood in the bed. What do you do next?