- النزف الهضمي الحاد Acute gastrointestinal (GI) hemorrhage
- مشكلة سريرية شائعة بتظاهرات عدة.ويتراوح من بسيط إلى جسيم،وينشأ من أي منطقة من السبيل الهضمي،الكبد والطرق الصفراوية،المعثكلة،يصنف حسب موقعه نسبة لرباط ترايتز.
- فإذا كان منشأه فوق رباط ترايتز يدعى علويا أما إذا كان تحته فيدعى سفليا.

التظاهرات السريرية:

- **النزف غالبا واضح للعيان:ربما:**
- **١.قَيءُ الدَّمHematemesis :قيء دم أحمر قان أو بشكل ثفل القهوة coffee grounds.**
- **وهو بشكليه (أو بالرشف عبر الأنبوب الأنفي المعدي)دلالة نزف هضمي علوي،وثفل القهوة بالذات يدل على تماس للدم النازف مع عصارة المعدة الحامضة لفترة كافية لتحويل خضابه إلى ميتهيموغلوبولين methemoglobin**
- **٢ .تغوط مدمى Hematochezia:خروج دم أحمر قان من الشرج،وهو أيضا ليس دلالة على أن النزف سفلي فقد يكون نزفا علوياً غزيرا مر سريعا.**
- **٣. تَغَوُّطُ أَسْوَدmelena:وهوأيضا يدل على تماس لفترة طويلة مع عصارة المعدة،ولايدل بالضرورة على أنه علوي.**

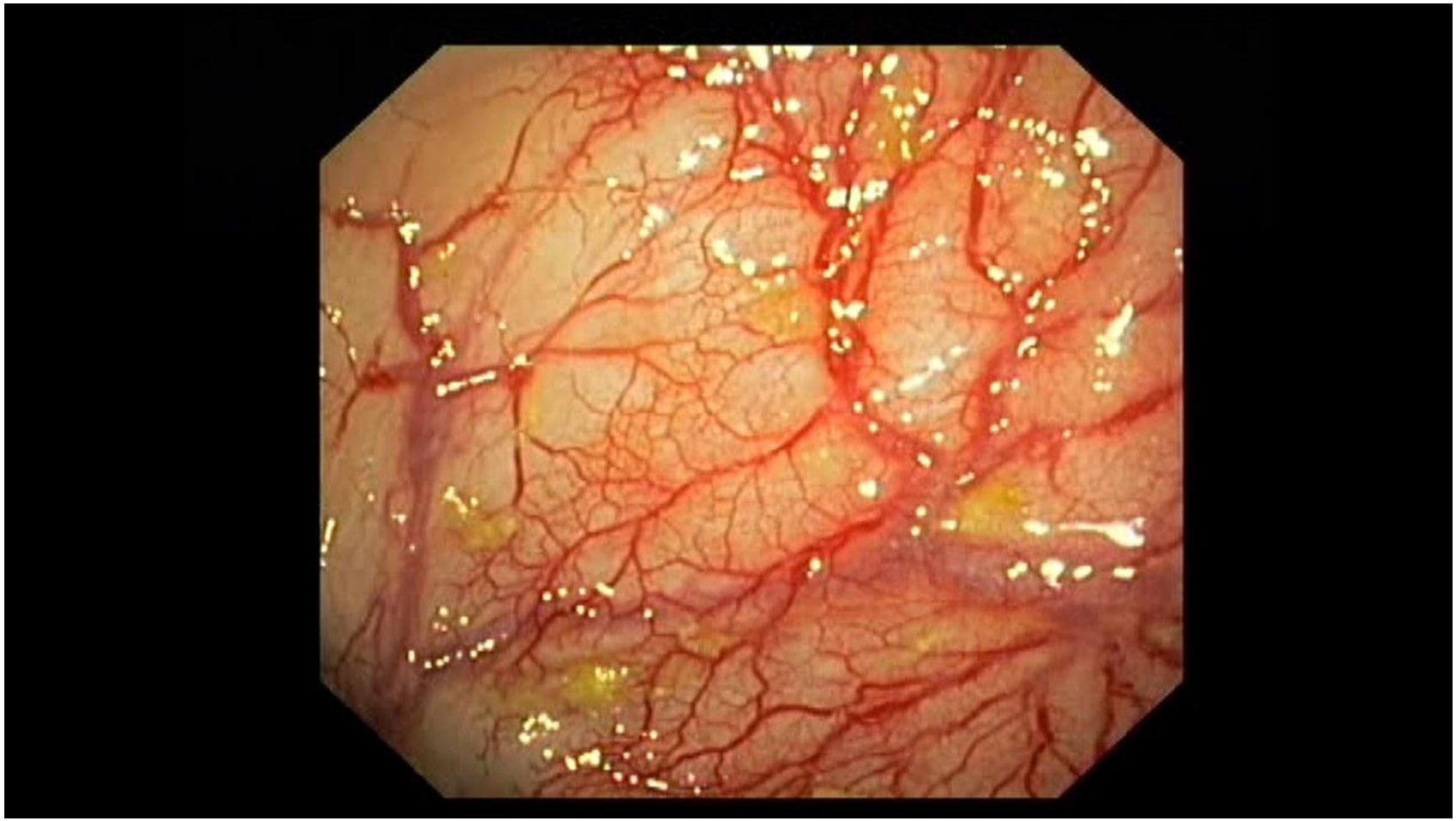
النزف الهضمي السفلي الحاد

TABLE 46-3 Differential Diagnosis of Lower Gastrointestinal Hemorrhage

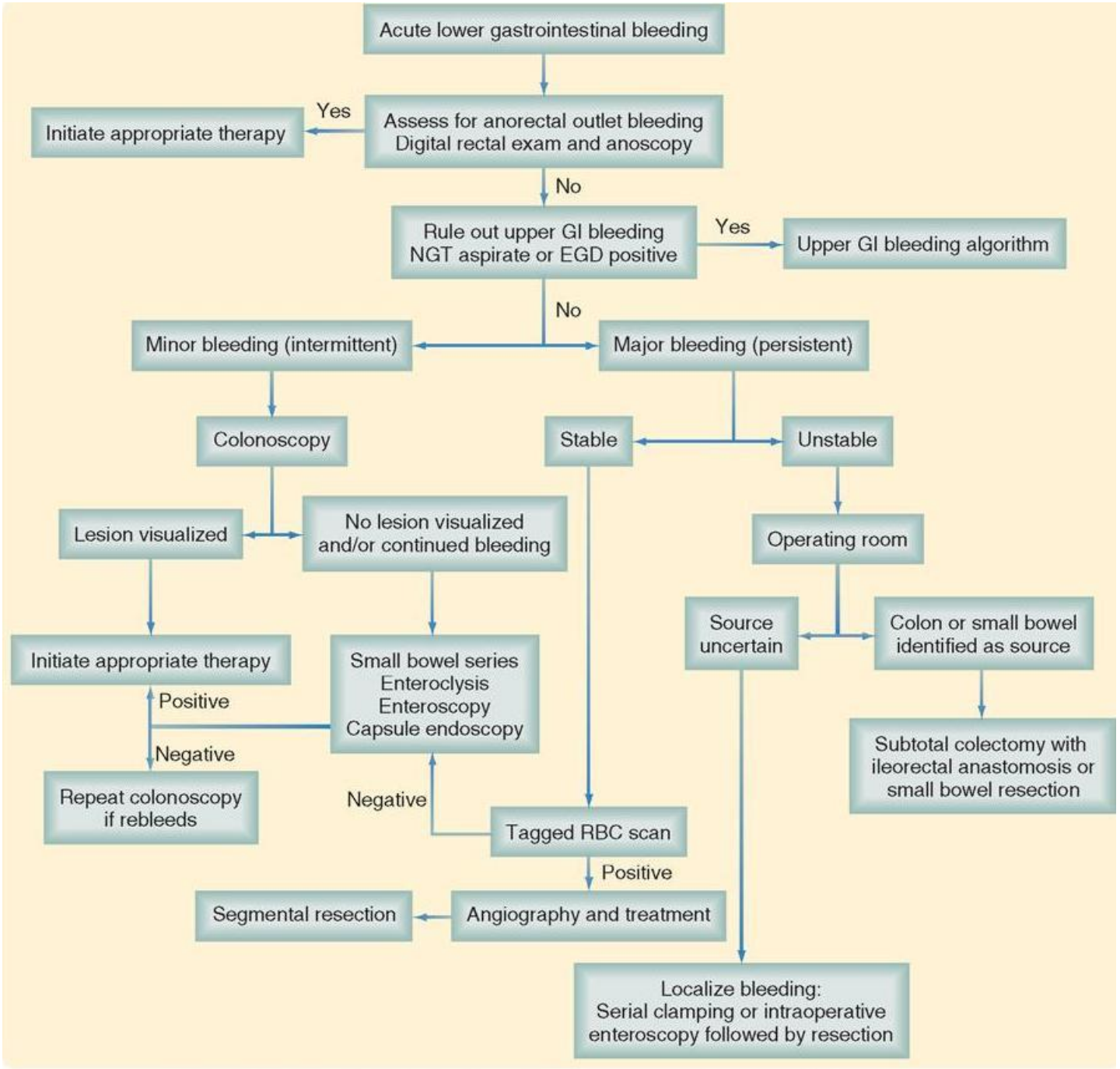
COLONIC BLEEDING	95%	SMALL BOWEL BLEEDING	5%
Diverticular disease	30%-40%	Angiodysplasias	
Anorectal disease	5%-15%	Erosions or ulcers (potassium, NSAIDs)	
Ischemia	5%-10%	Crohn's disease	
Neoplasia	5%-10%	Radiation	
Infectious colitis	3%-8%	Meckel's diverticulum	
Post-polypectomy	3%-7%	Neoplasia	
Inflammatory bowel disease	3%-4%	Aortoenteric fistula	
Angiodysplasia	3%		
Radiation colitis or proctitis	1%-3%		
Other	1%-5%		
Unknown	10%-25%		

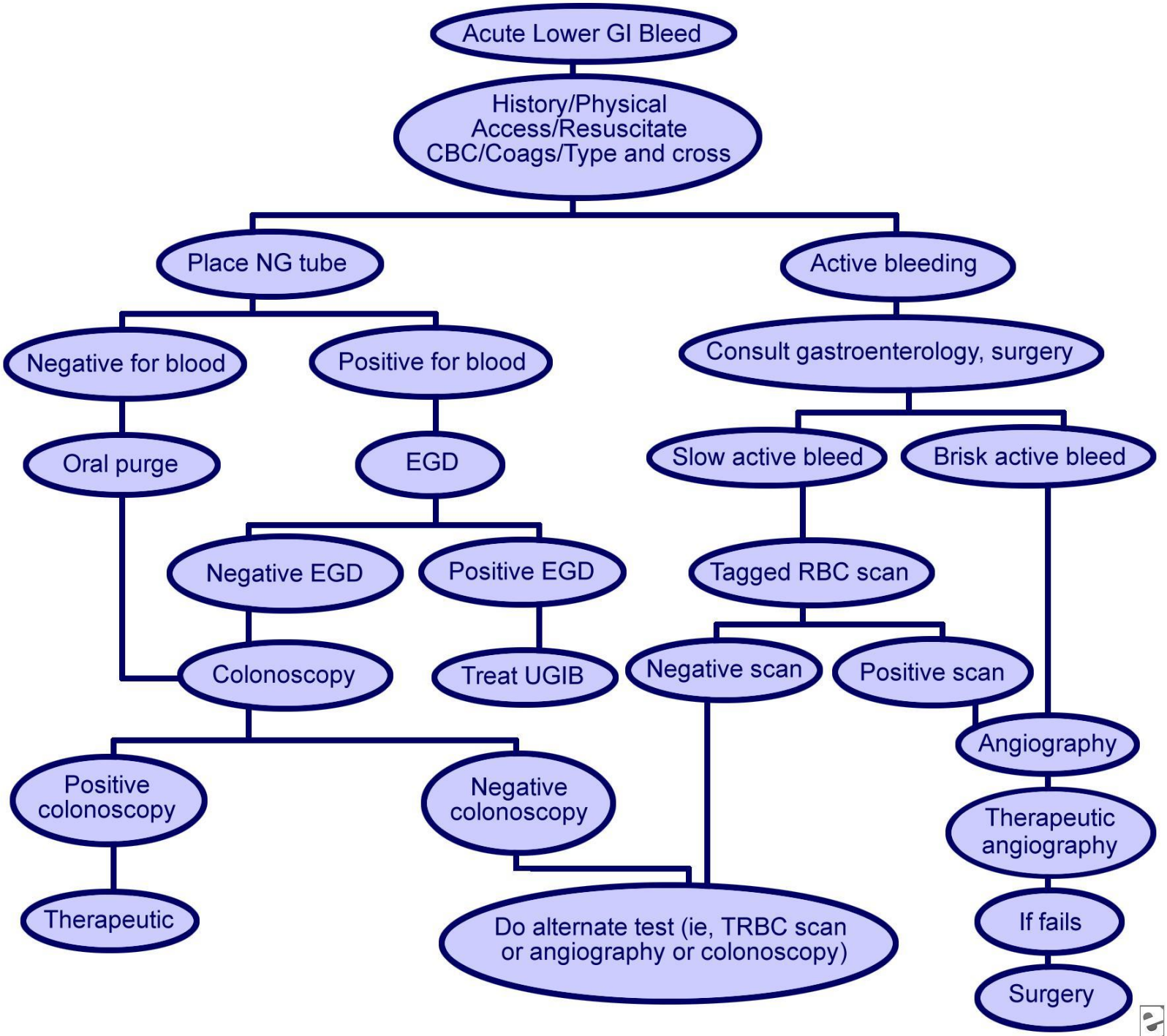
- الناسور الأبهري - العفجي **Fistula Aortoduodenal هو حالة إسعافية خطيرة جداً.**
- يصنف إلى نوعين:
- بدئي: **مريض لديه أم دم أبهرية، بسبب الانتان تتنوسر على القطعة الثالثة أوالرابعة من العفج وهو قليل المشاهدة.**
- ثانوي: **وهو أكثر شيوعاً ويحدث بعد معالجة أم دم أبهرية بوصلة صتعية ، قد تُنخر فيما بعد جدار العفج وتسبب ناسور أبهري عفجي.**

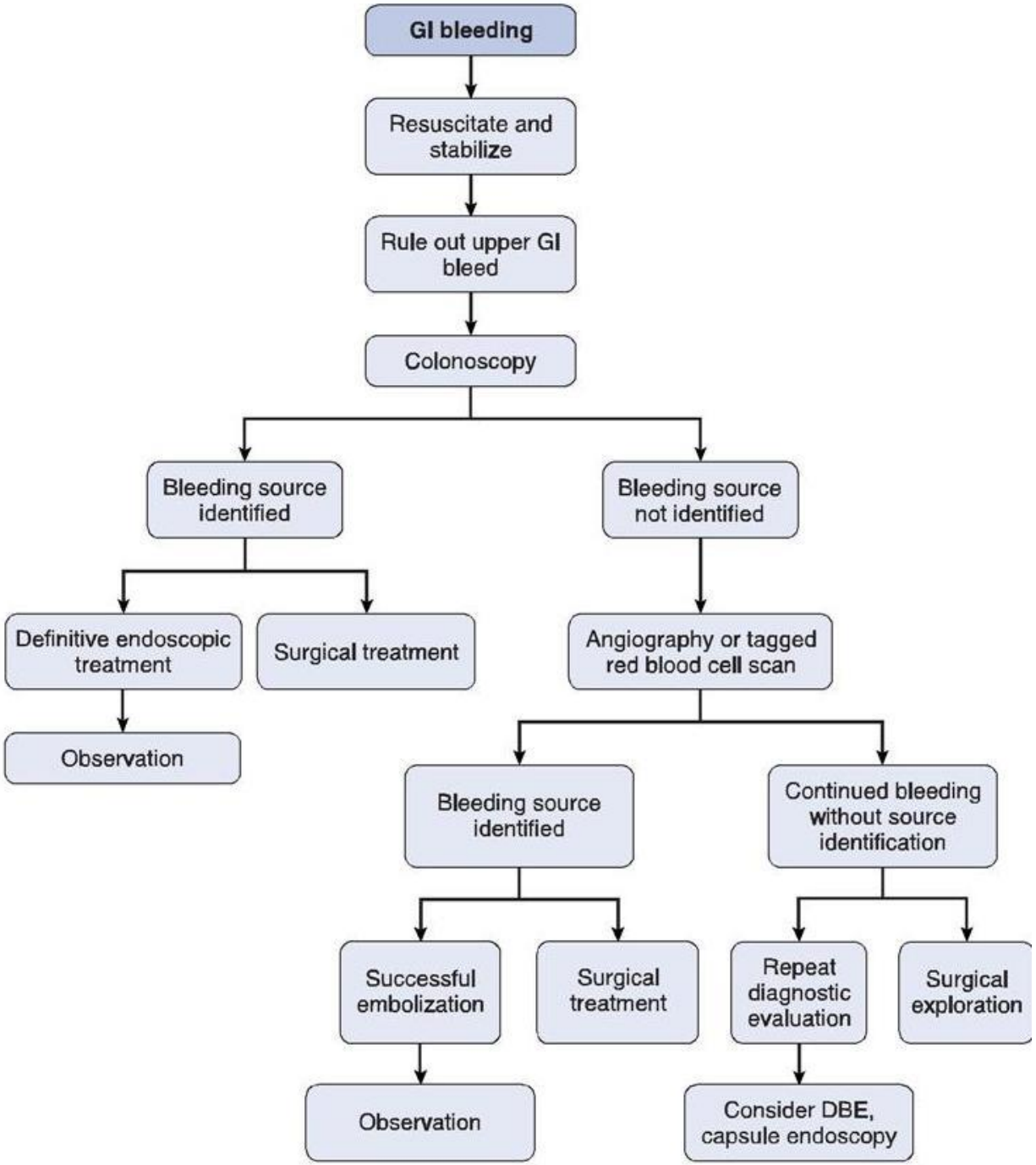
٥.خَلَلُ التَّنسُّجِ الوِعائِيّangiodysplasia:تشوهات وعائية تتوضع في الصائم والقولون الأيمن،وتسبب نزفا هضميا سفليا،تشخص بالتنظير وتعالج عبره بتخثير الأوعية بواسطة الليزر LASER.



- سوء التصنع الشرياني – الوريدي Arteriovenous Malformation**سببها تنكس يصيب الأوردة والوريدات)نادراً الشرايين(الموجودة بشكل خاص في الطبقة تحت المخاطية للسبيل الهضمي، حيث تتوسع هذه الأوعية وترق جدرانها مما**
يعرضها للنزف إما بسبب رض ميكانيكي)مرور البراز(أوبشكل عفوي. أشيع مكان لحدوث هذه الآفات هوالكولون الأيمن.


Acute lower gastrointestinal bleeding
Assess for anorectal outlet bleeding
Digital rectal exam and anoscopy
Yes
Initiate appropriate therapy
No
Rule out upper GI bleeding
NGT aspirate or EGD positive
Yes
Upper GI bleeding algorithm
No
Minor bleeding (intermittent)
Major bleeding (persistent)
Colonoscopy
Stable
Unstable
Lesion visualized
No lesion visualized
and/or continued bleeding
Operating room
Source
uncertain
Colon or small bowel
identified as source
Initiate appropriate therapy
Small bowel series
Enteroclysis
Enteroscopy
Capsule endoscopy
Positive
Negative
Repeat colonoscopy
if rebleeds
Negative
Subtotal colectomy with
ileorectal anastomosis or
small bowel resection
Tagged RBC scan
Positive
Segmental resection
Angiography and treatment
Localize bleeding:
Serial clamping or intraoperative
enteroscopy followed by resection


Acute Lower GI Bleed
History/Physical
Access/Resuscitate
CBC/Coags/Type and cross
Place NG tube
Active bleeding
Negative for blood
Positive for blood
Consult gastroenterology, surgery
Oral purge
EGD
Slow active bleed
Brisk active bleed
Negative EGD
Positive EGD
Tagged RBC scan
Colonoscopy
Treat UGIB
Negative scan
Positive scan
Angiography
Positive colonoscopy
Negative colonoscopy
Therapeutic angiography
Therapeutic
Do alternate test (ie, TRBC scan or angiography or colonoscopy)
If fails
Surgery


GI bleeding
Resuscitate and stabilize
Rule out upper GI bleed
Colonoscopy
Bleeding source identified
Bleeding source not identified
Definitive endoscopic treatment
Surgical treatment
Observation
Angiography or tagged red blood cell scan
Bleeding source identified
Continued bleeding without source identification
Successful embolization
Surgical treatment
Repeat diagnostic evaluation
Surgical exploration
Observation
Consider DBE, capsule endoscopy

CT angiography and magnetic resonance imaging (MRI)angiography

Surgery

Most patients with LGIB never need surgery; only approximately 10% to 25% of patients need operative intervention, either emergent or nonemergent. The surgical strategy depends on the intensity, cause, and localization of the bleeding. The indications for surgery include continued or recurrent hemorrhage despite nonoperative attempts at localization, ongoing hemodynamic instability, transfusion requirement of greater than 6 to 10 units, or pathologic finding requiring surgical intervention. There are no absolute predictors of who will need an operation, but 50% of patients who need 4 or more units of blood in the first 24 hours eventually need surgery. Morbidity and mortality increase significantly in patients who have received 10 or more units of blood.

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Every effort should be made to localize the bleeding source before surgery. If the patient's condition remains stable, diagnostic tests should continue until the source of bleeding is identified. When the bleeding site has been localized to the colon, segmental resections may be performed based on appropriate treatment for the underlying pathology. In the case of diverticular disease, the affected segment should be removed; in the case of cancer, an appropriate oncologic resection should be performed. Smaller wedge resections may be performed for a single bleeding AVM or ectasia. In the case of segmental resection for preoperatively identified source of bleeding, mortality rate is less than 10% in reported series. The rate of recurrent bleeding ranges from 0 to 15% after segmental colectomy for localized bleeding.

In cases where the bleeding cannot be localized before surgery, a thorough abdominal exploration may identify the source of bleeding.

Running the small bowel during surgery may identify a small bowel lipoma or Meckel's diverticula. On-table colonoscopy and enteroscopy occasionally identify an intraluminal source of bleeding. To facilitate this, patients should be placed in the lithotomy position in the operating room. With the surgeon's assistance, an upper or lower endoscope may be advanced through the small bowel to evaluate for sources of bleeding. The surgeon gently manipulates the small bowel over the scope to advance the scope. If necessary, an enterotomy may be created for "on-field" insertion of the endoscope to complete evaluation of the small bowel. When found, the affected segment of small bowel can be resected, such as in the case of a Meckel's diverticula or small bowel AVM.

If localization techniques are not successful, but the bleeding appears to be originating from the colon, an emergency total abdom-
inal colectomy (TAC) may be performed. TAC in this situation has a
mortality rate of 10% to 30% but a rebleeding rate of less than 1%.
If a more limited resection, such as segmental colectomy, is per-formed in this setting, the risk of rebleeding is approximately 35%
to 75%, with a mortality rate of 20% to 50%.

Some surgeons advocate subtotal colectomy even if the bleeding source is identified because of the morbidity and mortality associated with reexploration from a repeat LGIB. Studies have shown comparable mortality rates for subtotal colectomy and segmental resection, and a frank discussion is warranted with the patient and family in regards to the risk and benefits of each approach and the postoperative effects on the quality of life. One of the often reported drawbacks to the TAC includes postoperative diarrhea and fluid losses. Preserving the distal terminal ileum may minimize this complication if a subtotal colectomy is necessary.

The choice of whether to perform a primary anastomosis should be based on three criteria: (1) definitive diagnosis of source of bleeding; (2) patient stability; and (3) patient comorbidities. In a patientwith an unstable condition with a localized bleeding colonic segment, some have suggested a damage control approach; a temporizing surgical resection of the affected area is undertaken without an initial anastomosis or fecal diversion, accepting the necessity of a second-look operation. If the surgeon is not confident in the identification of the source of bleeding, an end ileostomy or colostomy is also suggested. Use of the end stoma helps elucidate the location of bleeding in the case of recurrence. In addition, use of temporary or permanent stoma should be based on the surgeon's clinical judgement of patient stability and ability to heal the anastomosis.

SUMMARY

The approach to massive LGIB involves a thorough history and physical examination with concomitant resuscitation. A multidisciplinary effort including endoscopists, radiologists, and surgeons working together can most effectively diagnose and treat sources of LGIB. Although most bleeding resolves spontaneously or with nonoperative techniques, localization of bleeding helps limit morbidity and mortality for those who need surgery. Appropriate surgical intervention depends on underlying pathology and the overall clinical picture.