PR bleeding

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| gastroenterology & hepatology,general surgery,intensive care,onthepods

James talks to Dr Cherry Koh on the management of PR bleeding on the wards.

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About Dr Cherry Koh

Cherry Koh is a cons l Hospital, Sydney. She completed her C Oxford and has a wide clinical and aca

PR bleeding

With Dr Cherry Koh, C New South Wales, Australia

Case

You are a JMO on t atient who has had some rectal bl

1. Ini

- Is the patient stable? Observations especially HR and BP
- How much has the patient passed and frequency of PR bleeding?

2. Common causes of PR bleeding

1. Haemorrhoids
   - Very common but a diagnosis of exclusion
   - Can be more significant as patients in hospital can be on heparin/clexane
2. Diverticular disease
3. Angiodysplasia

4. Ischaemic colitis or other colitis (e.g. Crohn's disease) – less common
5. Malignancy
6. Much less commonly rapid transit from upper GI bleeding e.g. peptic ulcer disease

3. What types of questions would help distinguish these causes of PR bleeding?

- Anal canal type bleeding e.g. fissure/haemorrhoids
    - Occurs at end of bowel motion, bright red, small volume and always occur with bowel motion
- Colonic sources of bleeding – diverticular or angiodysplasia bleeding
    - Patients
    - Sudden
    - Abdomi asovagal respons ith right sided ar rapid transit a

4. H er GI bleeding?

- For haematemes
- Upper GI bleedi R bleeding can occur when ther th tachycardia/hyp
- Ask about a hist n Mallory Weiss tears) or risk fac
- A disproportion st the patient is breaking down and absorbing blood in the GI tract.

5. What are the features to look for on examination?

- End of bed exam: Looks anxious, shut down, pale, cold/clammy hands (lost significant amount of blood)
- Vital signs: If hypotensive/tachycardic
- Abdomen: Any tenderness/peritonism. Tenderness may suggest underlying colitis. Pulsatile mass (for an aortoenteric fistula, but very rare)
- Digital Rectal Exam: perianal pathology or fissure, any obvious haemorrhoids (generally not palpable), review any melaena/PR bleeding on glove.

6. What investigations?

- FBC and G+H:
    - Urgent G+H necessary if there is a history of significant quantity of bleeding (e.g. toilet bowl full of blood and clots) or frequency (passing a motion every 30min or every hour with bleeding due to osmotic/cathartic effect of blood in the colon)
    - Crossmatch not always required unless significant quantity/frequency and haemodynamically unstable.
- EUC/CMP: useful for assessing urea:creatinine ratio
- LFTs: suggest al
- Coagulation: to

7. Ma

- 90-95% rectal b
- Initial principles and blood products)
- Reversing coagu
- **Does the patient**
    - For min e bleeding) many do ve comorbi high.
    - For pati dmission for monitor copy.
    - Heavy b bility need admission and urgent colonoscopy
- **General Principles of Ward Management**
    - Stool chart (important to assess severity of bleeding)
    - Strict fluid balance
    - Diet (Clear fluids still OK while awaiting possible colonoscopy)
    - Frequent review – if ongoing and heavy bleeding consider escalating

8. Specific management of different types PR bleeders

- **Torrential/massive PR bleeders:**

    - These patients are unstable, tachycardic, hypotensive. They respond to fluids but continue to bleed
    - Requires interventional CT angiogram which detects bleeding at a minimum 1mL/min and treats via embolisation.
    - As blood is irritant and has an osmotic pull within the colon need 80-100mL/hr PR bleeding to get a positive CT angiography result
- **Significant PR bleeders:**
    - These patients have sudden onset bleeds with clots e.g. passing a bowel motion every 30min-2hrs.
    - Admit and observe these patients. Most stop spontaneously.
    - Most related to diverticular disease/angiodysplasia.
    - Withhold blood thinners and outpatient colonoscopy can be done to confirm diagnosis.
    - Concern with bowel prepping these patients is that the bowel preparation can disrupt the clot and trigger more bleeding/morbidity.
- **Slow PR bleede**
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    - Bleedin
    - Alternat
    - Patients
    - Red cell
    - Semi-ele
    - Final res

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Useful tip: When doing a colorectal surgery consult about a patient with PR bleeding in ED/on the wards, the common things a registrar/fellow will want to know are:

- ***Patient factors**: age, reason for admission, current medications (antiplatelet therapy, aspirin, warfarin or dabigatran, heparin/clexane), surgical history (previous laparotomy or bowel surgery, haemorrhoid history)*
- *Onset and type of bleeding: very small episode in setting of constipation or a very large PR bleeding episode with haemodynamic instability (pale, hypotensive, tachycardic?)*
- ***Note view of bleeding**: bright red bleeding typical of anal canal bleeding or offensive smelling, tar like melaena?*

Related Podcasts

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- Upper GI bleeding

Tags: #Angiodysplasia,#Chron's disease,#coagulopathy,#colitis,#colonoscopy,#colorectal,#CT angiogram,#Diverticular,#diverticular disease,#fissure,#haemorrhoids,#Ischaemic colitis,#malignancy,#peptic ulcer disease,#rectal bleeding,#resuscitation,#stool chart