# GP CME

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GASTROENTEROLOGIST

16 AUG 18

# Case 1 DM

56 year old male

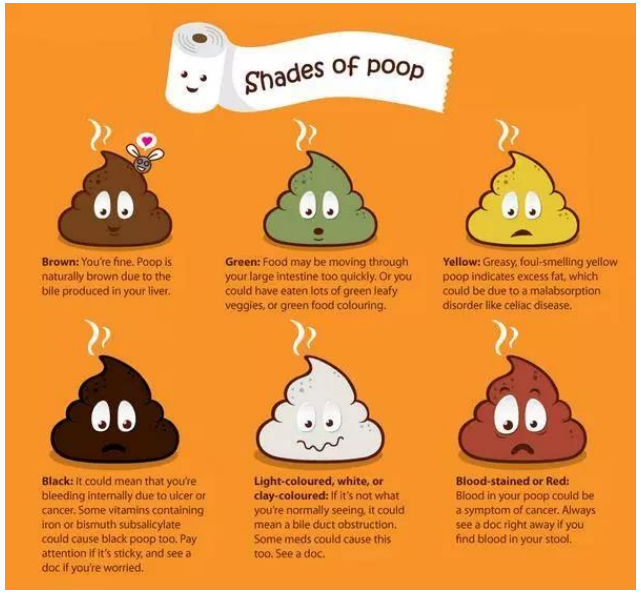
3 days history of dark stool

PMHx

Ischaemic heart disease: PCI to LAD

Osteoarthritis: Both knee

Recent toothache: Pain relief






Dark stool

- ? Melaena ? PR bleed ? Colour
- Frequency
- ? Haemetemesis

Medications

- Anti-platelets: Aspirin, clopidogreal, ticagrelor
- Anti-coagulants: warfarin, dabigatran….etc
- NSAIDS:
- Oral iron

Other history?

- Examination

# On examination

Fatigue, slight pallor

100/60, HR100, 98%%A, RR18

JVP0cm

CVS S1+S2+0

Chest clear

Abdomen: epigastric tenderness

PR: Black tarry stool on the glove

# Blood results

Hb 105, urea 13, Cr 100, LFTs normal

INR 1.0, Albumin 35

What is your next step?

# Peptic ulcer bleeding

5 % of Emergency Room admissions

80% stop spontaneously

10% mortality

Mortality increase significantly if rebleed

# Risk assessment

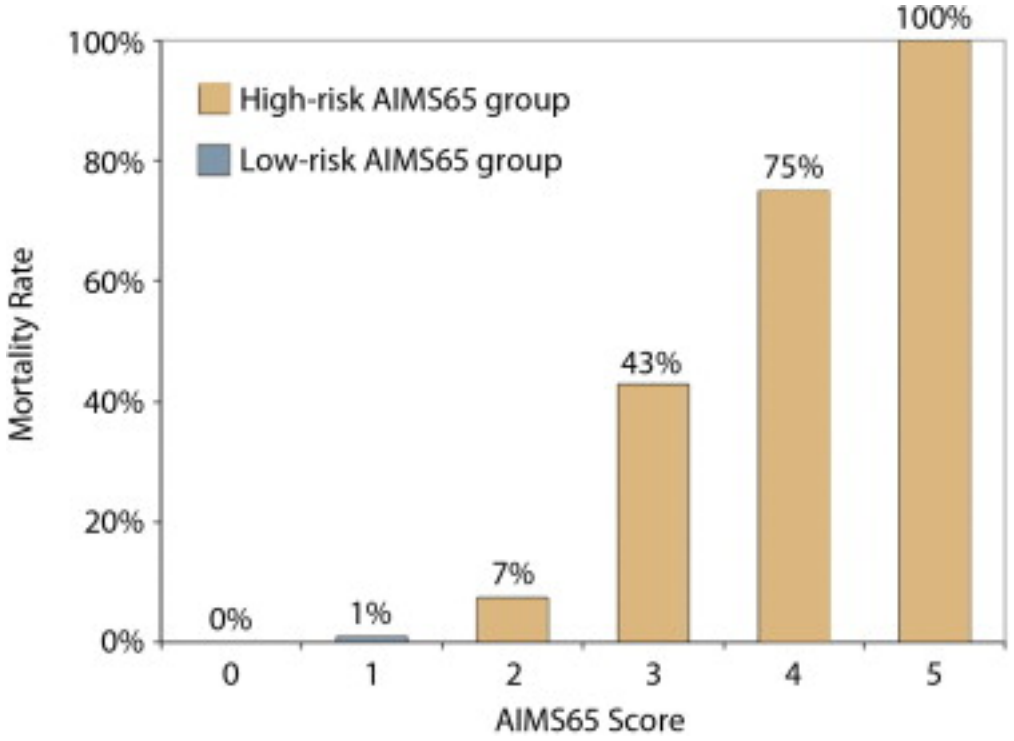
| Blatchford scoring system | |
|---|---|
| **Clinical parameter** | **score** |
| level of urea in serum (mol/L) | |
| • 6,5 - 8.0<br>• 8,0 – 10,0<br>• 10,0 – 25,0<br>• > 25,0 | • 2<br>• 3<br>• 4<br>• 6 |
| level of haemoglobin (g/L) m | |
| • 120 – 130<br>• 100 – 120<br>• < 100 | • 1<br>• 3<br>• 6 |
| level of haemoglobin (g/L) w | |
| • 100 – 120<br>• < 100 | • 1<br>• 6 |
| value of systolic blood pressure (mmHg) | |
| • 100 – 109<br>• 90 – 99<br>• <90 | • 1<br>• 2<br>• 3 |
| Rapid pulse > 100 / minute | • 1 |
| Melaena | • 1 |
| Syncope | • 2 |
| Liver failure | • 2 |
| Cardiac failure | • 2 |

1. Score 0
    1. Low risk for intervention
    2. Reasonable to manage as outpatient
2. Score >0
    1. Increased risk for intervention and inpatient management is recommended
    2. However most cases <5 respond without significant intervention
3. Score >5
    1. High risk for intervention

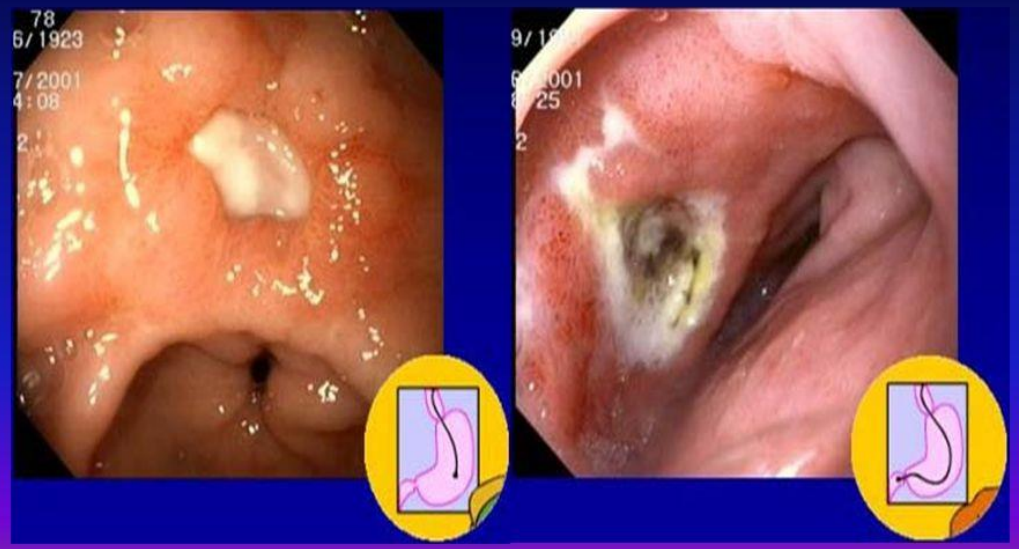
# Full Rockall score

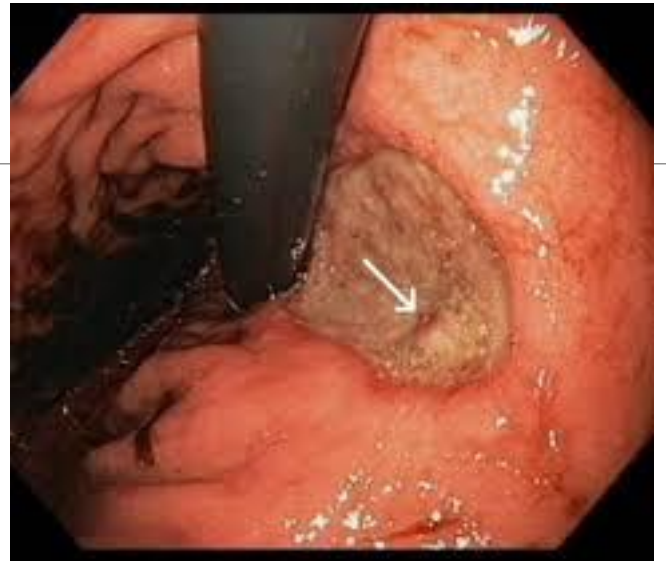
| | Score 0 | Score 1 | Score 2 | Score 3 |
|---|---|---|---|---|
| Age (y) | <60 | 60–79 | 80 | |
| Shock | Pulse <100 | Pulse >100 | Pulse >100 | |
| | Systolic BP >100 | Systolic BP >100 | Systolic <100 | |
| Comorbidity | Nil major | | Heart failure | Renal failure |
| | | | Ischaemic heart disease | Liver failure |
| | | | Any other illnesses | Disseminated cancer |
| Endoscopic stigmata | None | | Blood in GIT | |
| | Dark spot | | Adherent clot | |
| | | | Visible/spurting vessel | |
| Diagnosis | Mallory Weiss | All other diagnosis | Upper GI cancer | |
| | No lesion seen | | | |
| **Pre-endoscopy score** | **Risk of death (%)** | **Post-endoscopy score** | **Risk of death (%)** | **Risk of rebleeding (%)** |
| 7 | 75 (45–100) | 8+ | 40 (30–51) | 37 (27–47) |
| 6 | 62 (50–73) | 7 | 23 (15–31) | 37 (28–46) |
| 5 | 35 (27–43) | 6 | 12 (6–17) | 27 (20–34) |
| 4 | 21 (17–25) | 5 | 11 (6–15) | 25 (19–31) |
| 3 | 12 (9–16) | 4 | 8 (4–12) | 15 (10–21) |
| 2 | 6 (3–9) | 3 | 2 (0–4) | 12 (7–17) |

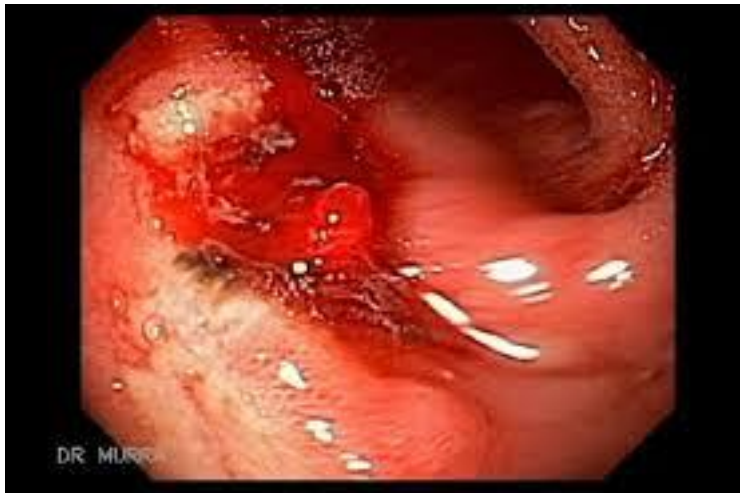
| AIMS65 Score | |
|---|---|
| Variable | Score |
| Albumin <3 g/dL | 1 |
| INR >1.5 | 1 |
| Systolic BP <90 mmHg | 1 |
| Altered Mental Status | 1 |
| Age >65 yr | 1 |
| **Scores >2 are considered high risk** | |




# Peptic Ulcers: Gastric & Dudodenal





# Summary

Establish clinical suspicions of UGIB

- History, examination, blood tests

Identify risk factors

- Blatchford score, rockall score, AMIS65

Stop the antiplatelets/anticoagulants

Fluid resuscitation if required.

Omeprazole

- oral omeprazole is as effective as intravenous therapy in terms of re-bleeding, surgery, transfusion requirements, hospitalization and mortality in patients with bleeding ulcers with low risk stigmata. These patients can be treated effectively with oral omeprazole.

Timing of endoscopy

# Case 2 KW

35 year old female

On the flight back from HK

While having meal on flight, felt something stuck in the throat

- painful to swallow since

PMHx

Asthma

# On examination

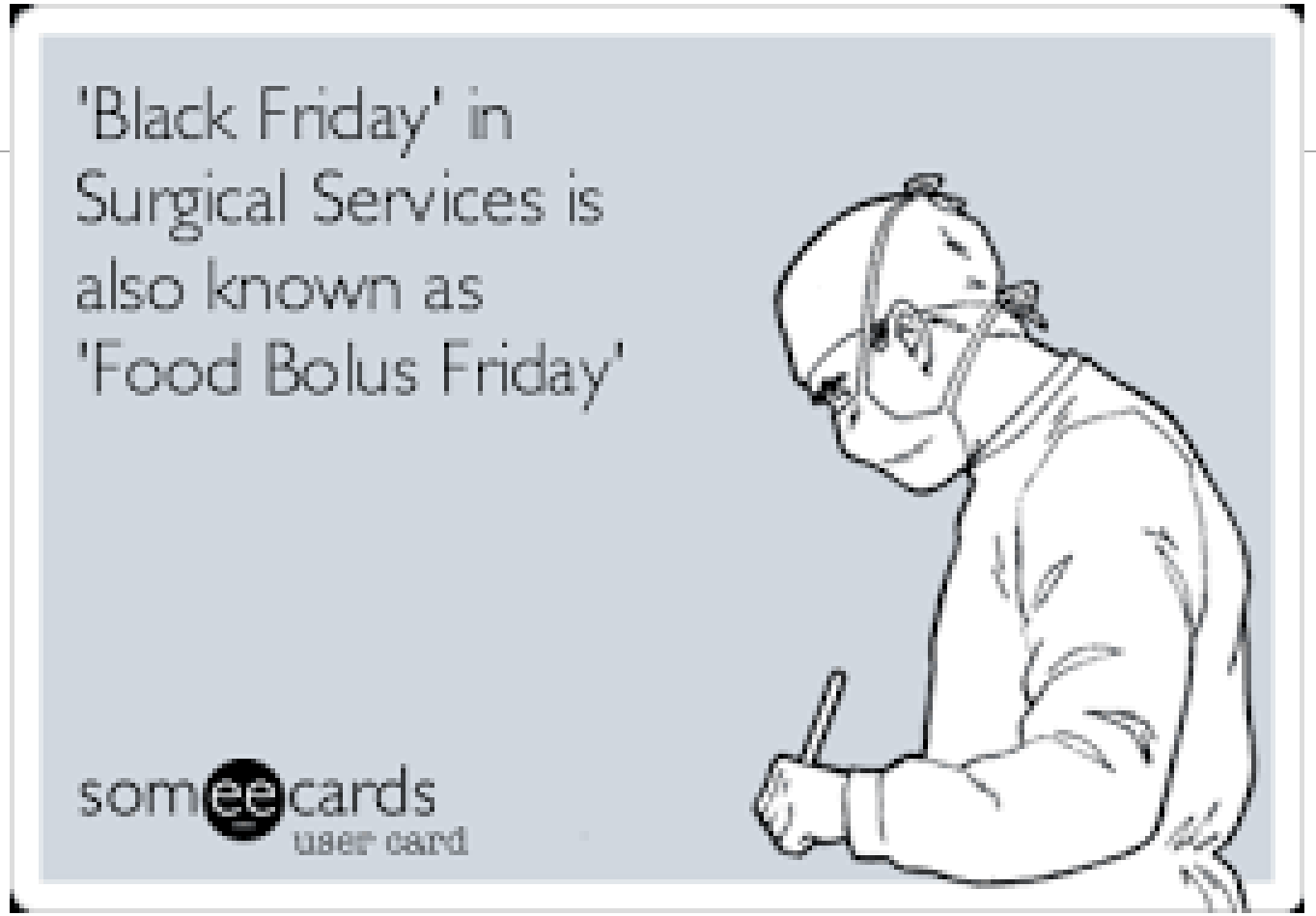
Distressed, unwell, anxious

Unable to swallow

Unable to swallow own saliva

Point towards mid-throat

What will you do next?


'Black Friday' in
Surgical Services is
also known as
'Food Bolus Friday'
someecards
user card

# Foreign body and food bolus

More common in paediatric populations: 75% coins

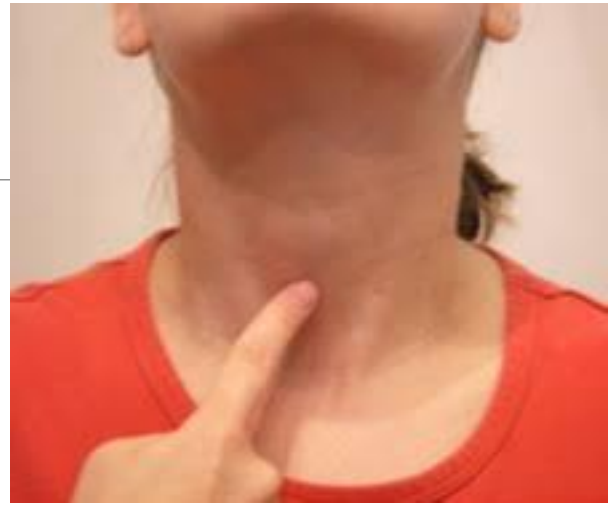
Adults

- Foreign body: psychiatric disorder, alcohol intoxication, drug overdose
- Food bolus: likely underlying pathology

80% pass spontaneously

Risks of impaction, obstruction and perforation: increase risk when > 24/24

# Initial assessment



Identify the ingestion

- Can be anything, any food
- Chicken, fish bone, BBQ meat, denture …etc

Locate the discomfort

- Doesn’t correlate the site of impaction
- Role of Xray
  - most foreign objects, steak bones, and free mediastinal or peritoneal air.
  - Radiographs can confirm the location, size, shape, and number of ingested foreign bodies and help exclude aspirated objects. However, fish or chicken bones, wood, plastic, glass, and thin metal objects are not readily seen

? Sign of oesophageal obstruction: unable to swallow own saliva

Airway management

# Anything you can try?

80% pass spontaneously

No single medical management strategy appears more effective than a ‘watch and wait’ approach

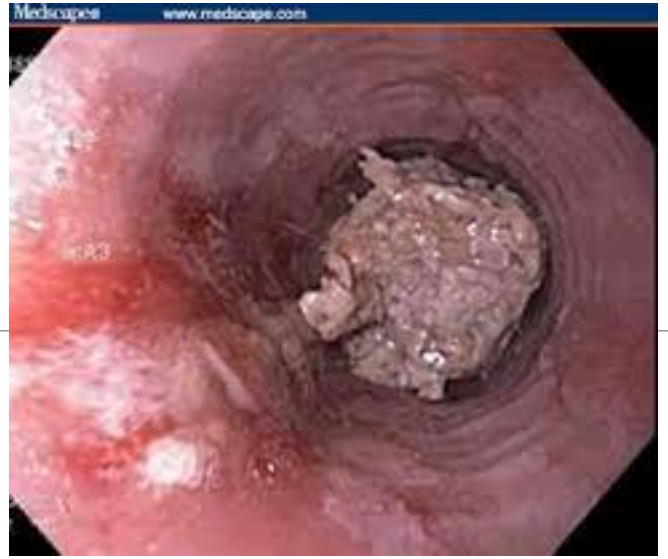
- Buscopan: widely used, lack of evidence
- Gas forming agents: positive study but small patients number
- Glucagon: inconsistent outcome
- Benzodiazepines

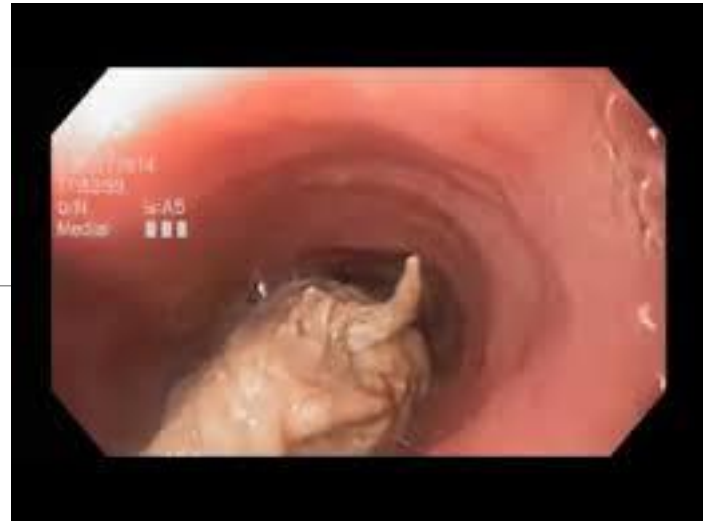
*The management of oesophageal soft food bolus obstruction: a systematic review*

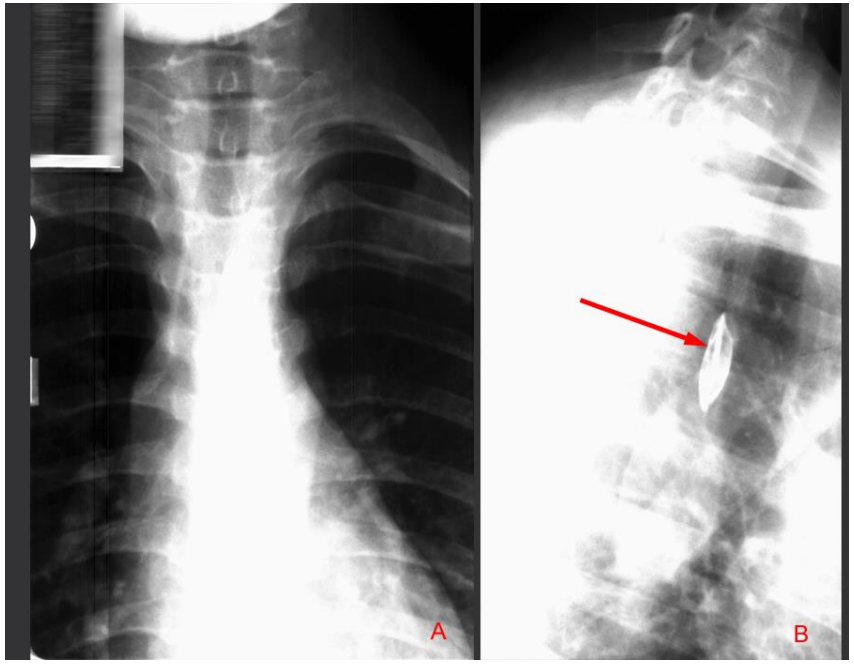
**TABLE 2. Timing of endoscopy for ingested foreign bodies**

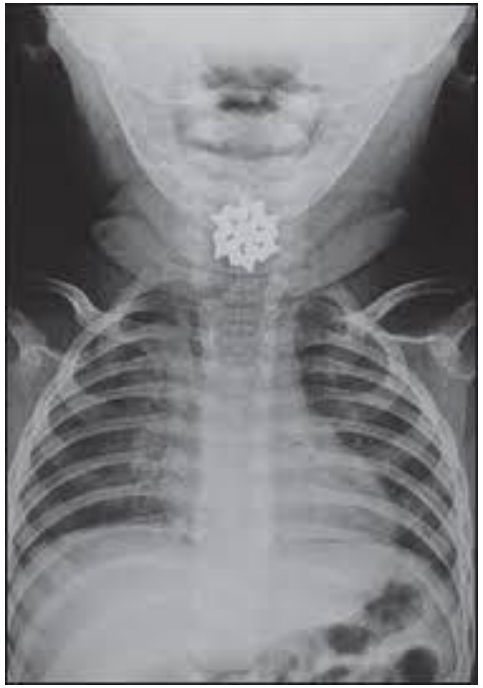
| |
|---|
| Emergent endoscopy |
| Patients with esophageal obstruction (ie, unable to manage secretions) |
| Disk batteries in the esophagus |
| Sharp-pointed objects in the esophagus |
| Urgent endoscopy |
| Esophageal foreign objects that are not sharp-pointed |
| Esophageal food impaction in patients without complete obstruction |
| Sharp-pointed objects in the stomach or duodenum |
| Objects >6 cm in length at or above the proximal duodenum |
| Magnets within endoscopic reach |
| Nonurgent endoscopy |
| Coins in the esophagus may be observed for 12-24 hours before endoscopic removal in an asymptomatic patient |
| Objects in the stomach with diameter >2.5 cm |
| Disk batteries and cylindrical batteries that are in the stomach of patients without signs of GI injury may be observed for as long as 48 hours. Batteries remaining in the stomach longer than 48 hours should be removed. |

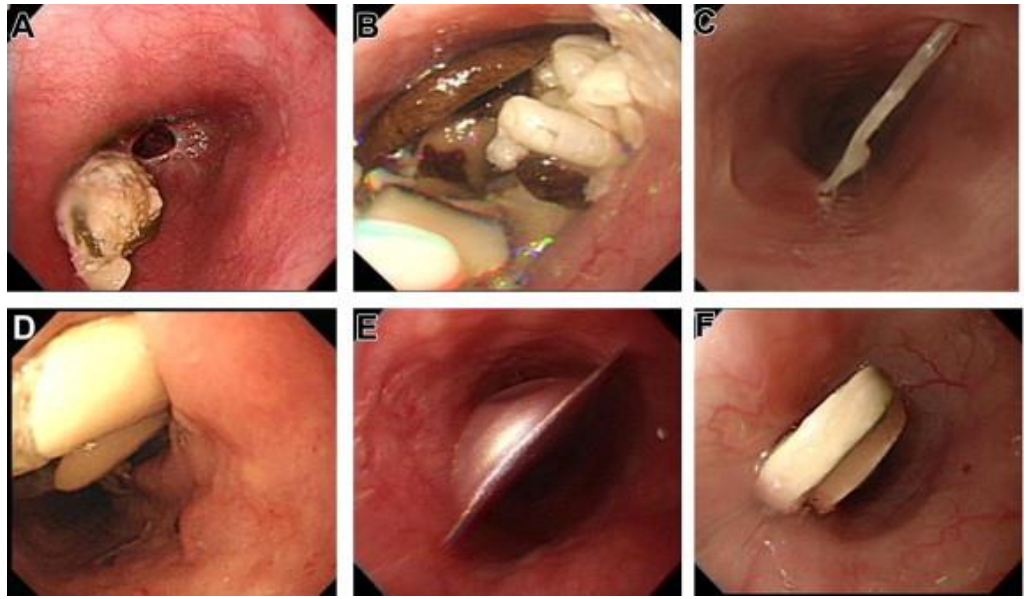

albertinen
Albertinen-Krankenhaus
Hamburg

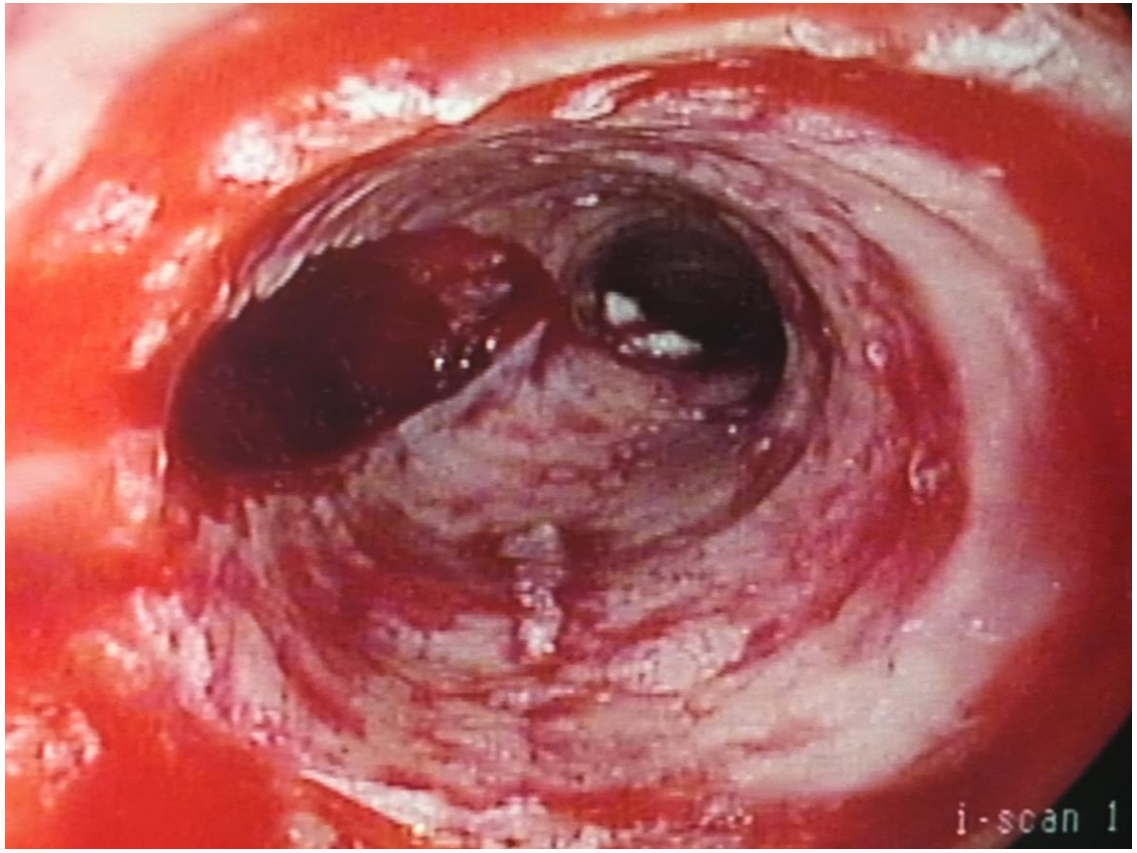

Medscape
www.medscape.com




A
B




A
B
C
D
E
F


i-scan 1

# Summary

- Establish clinical suspicion of food bolus/ foreign body ingestion
- What?
- When?
- Try any other drug?
- Urgent scope warranted?