Hematemesis

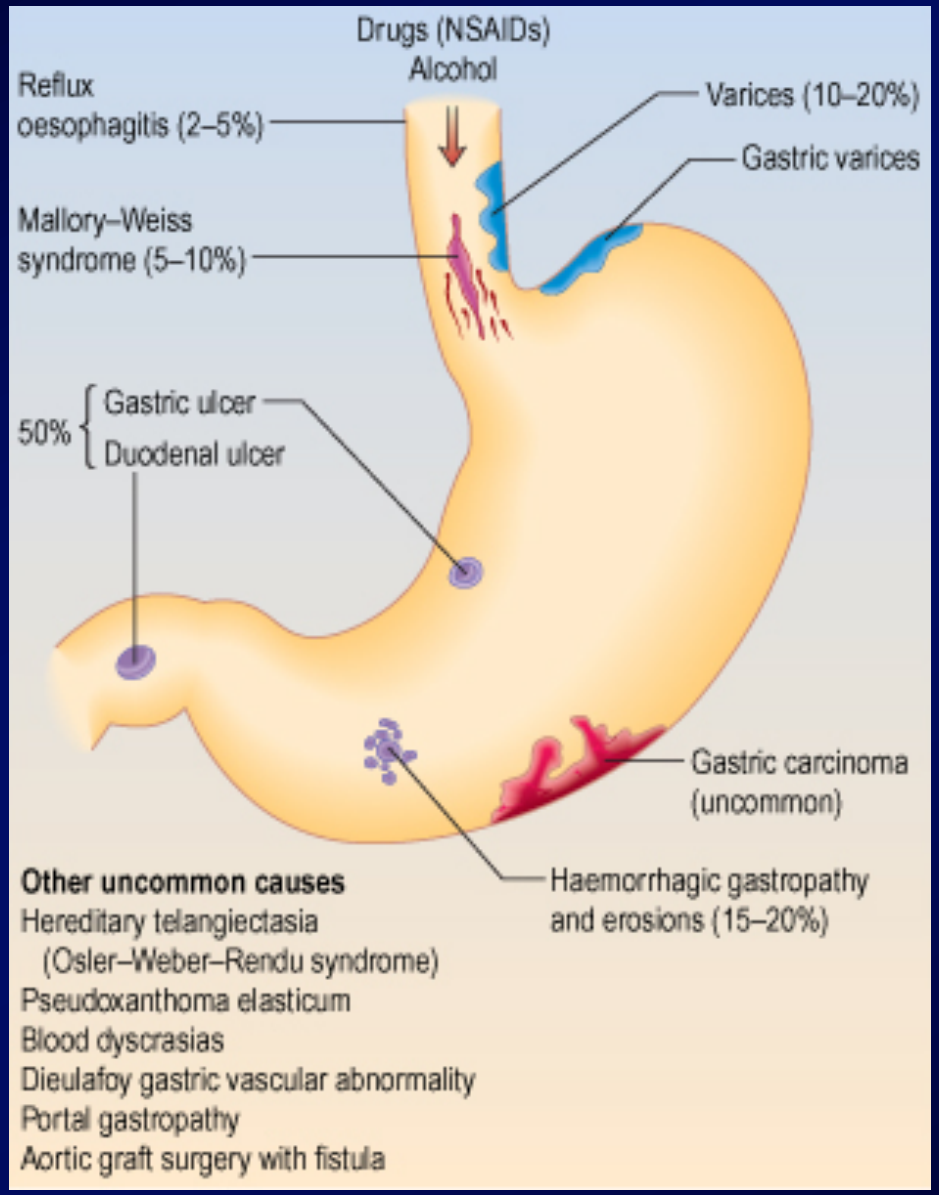
Immediate management

1. History and examination.
2. Monitor the pulse and blood pressure half-hourly.
3. Take blood for haemoglobin, urea, electrolytes, grouping and cross matching (2 units initially).
4. Establish intravenous access - central line if brisk bleed.
5. Give blood transfusion/colloid if the patient is *Shocked* (pallor, cold nose, systolic PB below 100 mmHg, pulse > 100/m
6. Oxygen therapy for shocked patients.
7. Urgent endoscopy in shocked patients or suspected liver disease. Endoscopy can detect the cause of the haemorrhage in 80% or more of cases.

Causes of Hematemesis

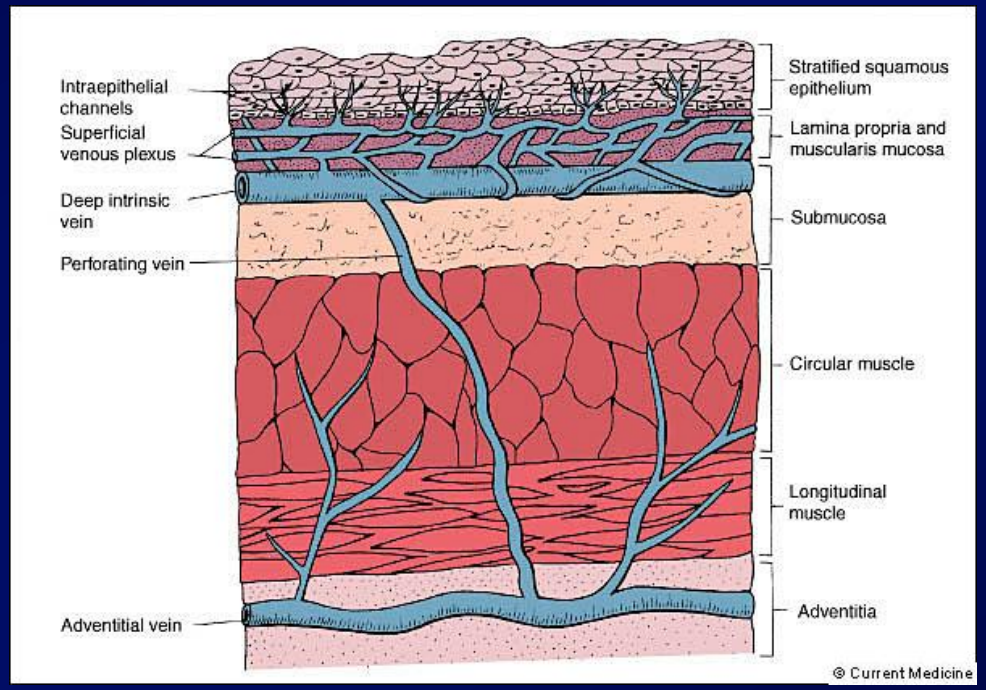
1. Esophageal varices, gastric varices.
2. Peptic ulcer (gastric or duodenal)
3. Aspirin or non steroidal anti-inflammatory drugs (NSAIDS).
4. Reflux esophagitis
5. Malignancy; Cancer stomach, cancer esophagus.
6. Heamorrhagic gastropathy or erosions.
7. Rare causes: Mallorry_wiss syndrome, hereditary telangiectasia, blood dyscrasia.

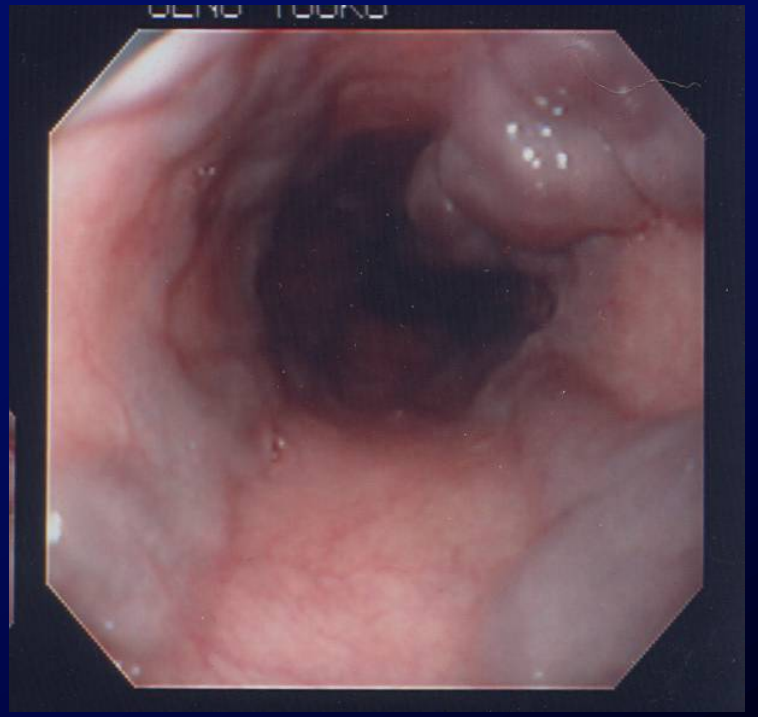
Causes of Hematemesis



1. *Esophageal & gastric varices*

- Dilatation of venous collaterals at the gastroesophageal junction due to portal hypertension. The collaterals are superficial in situation and tend to rupture and cause massive bleeding.





Management of variceal bleeding

- Prevention of recurrent variceal bleeding

1. Non-selective beta-blockade by propranolol therapy.
2. Endoscopic treatment. The use of repeated courses of banding at 2-weekly intervals leads to obliteration of the varices.
3. Transjugular portosystemic stent shunts.
4. Surgical portosystemic shunting

Management of variceal bleeding

- Initial management of acute variceal bleeding

1. Urgent endoscopy should be performed to confirm the diagnosis of varices.
2. Injection sclerotherapy or variceal banding to arrest bleeding by producing vessel thrombosis
3. Vasoconstrictor therapy to restrict portal inflow by splanchnic arterial constriction e.g. Terliptressin injection every 6 hours.
4. Balloon tamponade (Sungstaken tube) is used mainly to control bleeding if endoscopic therapy or vasoconstrictor therapy has failed or is contraindicated or if there is excessive hemorrhage.